2014

# The Effects of Acknowledging Cultural Differences on Therapeutic Alliance in Cross-Cultural Therapy

Jean-Pierre Assouad
*Philadelphia College of Osteopathic Medicine*, jeanpierreassouad@pcom.edu

Philadelphia College of Osteopathic Medicine

Department of Psychology

# THE EFFECTS OF ACKNOWLEDGING CULTURAL DIFFERENCES ON THERAPEUTIC ALLIANCE IN CROSS-CULTURAL THERAPY

Jean-Pierre Assouad

Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Psychology

June 2014

PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE
DEPARTMENT OF PSYCHOLOGY

**Dissertation Approval**

This is to certify that the thesis presented to us by Jean-Pierre Assouad on the 8th day of May, 2014, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

**Committee Members' Signatures:**

**Bruce S Zahn, EdD, ABPP, Chairperson**

**Beverly White, PsyD**

**Charmaine Chan, DO**

**Robert A DiTomasso, PhD, ABPP, Chair, Department of Psychology**

## Acknowledgements

First and foremost, I'd like to thank my family and loved ones for their support throughout the years. A special thanks for the support and encouragement that I received from my father, Jean, and my brother, George. I would like to thank my dissertation chair, Dr. Zahn, for his support, guidance and encouragement throughout this process and during my time at PCOM. I would like to thank the other members of my committee, Dr. White and Dr. Chan, for their support and guidance over the course of this project. I would also like to thank Dr. DiTomasso for his consultation on this dissertation, and Dr. Golden for her support and for allowing me to conduct my research at the Center for Brief Therapy.

Finally, I'd like to dedicate this work to my mother, Samia, whose love I felt every day as I journeyed towards this achievement, and now as I go forward.

## Abstract

Therapeutic alliance has been documented to have a significant impact on therapy. This study examined the impact that acknowledging visible cultural differences in the first session of treatment has on therapeutic alliance, perceived clinician cross-cultural competency, and potential attrition. A vignette study design was utilized with 26 subjects who were patients at the PCOM Center for Brief Therapy. The patients were randomly assigned one of four vignettes that consisted of a cross-cultural therapy situation, in which visible cultural differences were either addressed or not by a clinician. Following the reading of the vignette, the subjects were asked to complete the Working Alliance Inventory-Client Version, the client modified version of the Cross Cultural Counseling Inventory-Revised, and a Client Attrition Questionnaire. The results of the study indicated a significant difference in perceived clinician cultural competency in a situation where a clinician acknowledges multiple cultural differences rather than a single difference. A significant negative correlation was found between age and therapeutic alliance as a whole. Female subjects were also found to be significantly more likely than male subjects to make a higher rating of their potential to prematurely drop out of treatment. Future research should expand beyond the vignette model and utilize an intervention study to focus on the impact of broaching visible cultural differences in cross-cultural therapy during the first session of treatment.

## Table of Contents

## List of Tables

# Chapter 1: Introduction

## Statement of the Problem

Client attrition from psychological services has been shown to be an issue for many psychologists and clinicians who are practicing in the field. Current data reveal that dropout rates in mental-health services are at an alarming level. Reports of client dropout after the first session of treatment ranged from 20 to 57% (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008). Early withdrawal from treatment has been shown to be as high as 47% across settings, with a dropout rate of 65% prior to the 10$^{th}$ session (Barrett et al., 2008). Attrition is a problem in the mental-health field because it does not allow a clinician to deliver mental-health services in an effective manner (Barrett et al., 2008). Clients may not have the opportunity to experience relief from their symptoms because of the premature dropout.

The therapeutic alliance is a construct that has shown to impact treatment outcomes. Therapeutic alliance is defined as "the collaborative and affective bond between clinician and client" (Martin, Garske, & Davis, 2000, p. 438). This bond has been shown to be an essential part of the therapeutic process. In a meta-analysis of 79 studies, Martin et al. (2000) found a moderate relationship between therapeutic alliance and treatment outcomes. The authors also discovered that a client will experience the relationship with his or her clinician as therapeutic if an alliance has been developed. This effect occurs regardless of the treatment modality that is utilized (Martin et al., 2000). These findings highlight the importance of the therapeutic alliance in the psychotherapeutic relationship.

Therapeutic alliance has also shown to be a factor in predicting attrition in treatment. In a study of 248 subjects (157 male, 91 female) who were taking part in individual treatment for substance abuse or dependence, Cournoyer, Brochu, Landry, & Bergen (2007) sought to measure the predictive power of the therapeutic alliance on attrition rates and client behavior. In a drug rehabilitation program, therapeutic alliance was found to be a factor in client dropout. The authors discovered that the key factors regarding therapeutic alliance are the clients' views of their own commitment to therapy, their working capacity, and their perception of the clinician as understanding and involved (Cournoyer et al., 2007). Sharf, Primavera, and Diener (2010) investigated the impact of therapeutic alliance on client dropout. The authors discovered that therapeutic alliance acts as a strong indicator of client attrition and that those with higher levels of therapeutic alliance were more likely than those with lower levels to stay in treatment. Cournoyer et al. (2007) also found the clinician rated scales for client perseverance in treatment to be particularly predictive of client dropout.

The therapeutic alliance between a clinician and a client has been found to peak during the third session (Saltzman, Leutgert, Roth, Creaser, & Howard, 1976). In a study of 91 subjects (36 male, 55 female) in a university counseling center setting, Saltzman et al. (1976) discussed the tentative relationship that may take place between a clinician and client after the first session. The authors discussed that by the third session, the client and clinician have a greater understanding of the sustainability of their relationship (Saltzman et al., 1976). Although therapeutic alliance may peak by the third session, as many as half of the clients do not return after the first session (Cournoyer et al., 2007).

Culture has been demonstrated to be a factor in the development of therapeutic alliance. Vasquez (2007) discussed the impact that a clinician's choice to address culture in treatment can have on therapeutic alliance. The author also discussed the underutilization of therapy by ethnic minorities and the high attrition rates of ethnic minorities. Vasquez hypothesized that this finding may be the result of the client not experiencing an effective therapeutic alliance with the clinician. A clinician's multicultural orientation (MCO) has also been shown to impact the client's view of clinician credibility (Owen, Tao, Leach, & Rodolfa, 2011). MCO is defined as, "a 'way of being' with the client, guided primarily by therapists' philosophy or values about the salience of cultural factors (e.g., racial/ethnic identity, client's cultural background) in the lives of therapists as well as clients" (Owen et al., 2011, p. 274). The authors found that a client's perception of a clinician's MCO can impact the psychological health and well-being of ethnic minority clients (Owen et al., 2011). These findings support the view that the approach a clinician takes towards multicultural issues can have a significant impact on a client's perception of treatment and the therapeutic relationship.

Broaching the topics of race, ethnicity, and culture has been shown to lead to positive experiences in the therapeutic process. The definition of *race* mirrors that of the American Psychological Association (2003), which is based on the determination that race is socially constructed rather than biologically. Race, therefore, is a "category to which others assign individuals on the basis of physical characteristics, such as skin color or hair type, and the generalizations and stereotypes made as a result" (American Psychological Association, 2003, p. 380). The term *ethnicity* is also a concept that does not have an agreed upon definition (American Psychological Association, 2003). The

definition for ethnicity in this study is also derived from the American Psychological Association (2003), which defines ethnicity as "the acceptance of the group mores and practices of one's culture of origin and the concomitant sense of belonging" (p. 380). Concerning race, the discussion of this topic between European American clinicians and African American clients has been found to lead to a positive experience for both the clinician and the client (Knox, Burkard, Suzuki, & Ponterotto, 2003). Day-Vines et al. (2007) also found that a possible perception of cultural bias may take place if a clinician does not address the topic of race in appropriate situations. The authors further indicated that clinicians who have discussed cultural differences with their clients increase their credibility with those clients (Day-Vines et al., 2007).

Although support exists for the discussion of culture between the clinician and the client, these discussions do not frequently take place in cross-cultural therapy. Cross-cultural therapy's operational definition is derived from Hays' (1996) description of culture and consists of the coming together of a clinician and client for therapeutic services who are from differing age/generation, disability, religion, ethnicity/race, social status, sexual orientation, indigenous heritage, national origin, and gender. Maxie, Arnold, and Stephenson (2006) sought to measure whether clinicians address ethical and racial differences in cross-cultural psychotherapy. The authors sampled 689 APA-licensed psychologists and found that 85% of those sampled reported discussing cultural differences with their clients. However, pertaining to conversations with cross-ethnic/racial therapy cases, only 43% reported having such discussions with their clients (Maxie et al., 2006).

Research indicates that European American clinicians may not have a great deal of experience in cross-cultural therapy (Knox et al., 2003). Knox et al. (2003) found that European American clinicians had a lack of experience in addressing racial differences in their work, which the authors contributed to their lack of experience in the field. The authors discovered that only the European American clinicians had reported feeling uncomfortable with addressing race, but that both European American and African American clinicians found the discussions to be a positive experience (Knox et al., 2003).

## Current Problem

The problem that this study investigated takes into consideration the previously-mentioned issues relating to attrition, therapeutic alliance, and addressing culture in treatment. Additional studies are needed to investigate the impact that acknowledging culture in cross-cultural therapy has on therapeutic alliance. Research is also needed to better understand the impact that timing can have in determining when such acknowledgements should take place. The need exists to effectively and appropriately increase therapeutic alliance in the early stages of cross-cultural therapy in order to decrease attrition rates and improve the likelihood of achieving treatment goals.

## Purpose of the Study

Although the research on the impact of therapeutic alliance on therapy is abundant, investigation is lacking on ways to improve therapeutic alliance in cross-cultural therapy. Research has suggested that acknowledging culture in therapy is not a widely used practice (Maxie et al., 2006) and that such acknowledgement can have a positive impact on therapy (Day-Vines et al., 2007). This study examined the effect of

acknowledging visible cultural differences on therapeutic alliance during a hypothetical intake session when there was a visible cultural difference between the clinician and the client. The visible cultural difference was based on race and age. A better understanding of the impact of acknowledging culture in cross-cultural therapy will serve to increase clinician efficacy and client satisfaction. The study investigated whether the acknowledgement of cultural differences leads to a reduction in potential treatment attrition rates. Research has demonstrated that increasing therapeutic alliance can be a powerful tool in decreasing client attrition (Sharf et al., 2010). This study attempted to directly affect this facet of therapy as quickly as possible through the intake session. The study also investigated whether the hypothetical acknowledgement of cultural difference impacts the client's perception of the clinician's cultural competency. Cultural competency can certainly have an impact on cross-cultural therapy with culturally different minorities. Investigating how the intervention is impacting the client's perception of the working alliance is therefore of great importance. This study also built upon the past research on the impact of therapeutic alliance on therapy and specifically on cross-cultural therapy.

## Chapter 2: Review of Literature

### Therapeutic Alliance

Therapeutic alliance is a concept that can have a great deal of influence on psychological treatment. However, in order to understand therapeutic alliance, one must develop an operational definition of the term. The varying definitions of therapeutic alliance differ based on one's theoretical perspective. Therapeutic alliance can be understood as different therapeutic processes interacting between the client and clinician in psychological treatment (Elvins & Green, 2008). A clinician's credibility as an expert along with the clinician's engagement in treatment are also factors that are part of the therapeutic alliance (Elvins & Green, 2008). Therapeutic alliance has also been proposed to include the following three components: working alliance, empathic resonance, and mutual affirmation (Orlinsky & Howard, 1975). These concepts have been further broken down into the relationship aspects related to the agreement of goals, the assignment of tasks, and the development of bonds (Bordin, 1979). Bordin's (1979) view can be considered atheoretical, and he emphasized that the mutual development of goals was related to ameliorating the pain that the client is experiencing and should not be overlooked. Bordin (1979) expressed that the assignment of tasks to the client should be linked to the goals that the client is attempting to achieve. The bond is a component that looks at the relationship between the clinician and the client (Bordin, 1979). The bond should involve trust and can differ based on the experience between the clinician and the client and the approach that the clinician takes towards treatment (i.e. a client-centered vs. a caretaker-based interaction). Therapeutic alliance can also be understood as rooted

in psychodynamic principles, such as the client's perception of the clinician providing help and the client's perception of treatment as being goal oriented (Luborsky, 1984). These differing outlooks demonstrate that therapeutic alliance can be viewed in different ways depending on the psychological foundation in which one is grounded.

Therapeutic alliance has shown to be a factor that can decrease attrition. Barrett et al. (2008) discussed the positive impact that the therapeutic alliance has on treatment outcome. Weak therapeutic alliance has been shown to lead to increased client withdrawal, and attending to the problems in the alliance has shown to decrease attrition (Tryon & Kane, 1993). Barrett et al. (2008) suggested directly addressing the issues that cause the rupture in hopes of healing the therapeutic alliance.

Sharf et al. (2010) also found therapeutic alliance to be a factor that has a significant impact on attrition. They discovered that clients with a weaker level of therapeutic alliance have a higher likelihood of dropping out of treatment. They found that the effect size of therapeutic alliance was more robust than social-class variables (Sharf et al., 2010). Certain variables, however, were found to have an impact on the effect size between therapeutic alliance and attrition. Weaker associations between therapeutic alliance and attrition were discovered in studies dealing with clients who had a high-school education or higher. Stronger effect sizes were found in long-term treatment studies (16 - 40 sessions) and inpatient settings (Sharf et. al., 2010).

Similar results were found by Startup, Wilding, and Startup (2006) in reviewing the impact of therapeutic alliance on attrition in treating acute psychosis. The authors utilized cognitive-behavioral therapy (CBT) in the treatment of clients who were

admitted to psychiatric hospitals as a result of experiencing acute psychotic episodes and meeting the diagnostic criteria of schizophrenia, schizophreniform or schizoaffective disorder. The initial study sample consisted of 43 clients who were randomly assigned to a control group utilizing their current treatment and 47 randomly assigned to a group utilizing their current treatment plus CBT. However, because of patient dropout, the final sample consisted of seven women and 22 men, with the mean age being 29.7 years. The procedures involved the authors administering both the Active Engagement Scale and the Working Alliance Inventory (WAI) to the subjects in order to assess therapeutic alliance. In comparing the results of these measures with clients who dropped out of treatment prematurely to those who completed the course of treatment, the authors discovered a significant difference in therapeutic alliance scores (Startup et al., 2006). The authors found significant differences in the recovery style and engagement between the participant groups, along with differences in the Goal and Task subscales of the WAI. Clients who dropped out of treatment were less engaged in treatment and agreed less with their therapist in comparison to those who remained in treatment (Startup et al., 2006).

Specific counselor behaviors have been found to predict therapeutic alliance. Duff and Bedi (2010) investigated the relationship between 15 client-identified factors and their impact on therapeutic alliance strength. Their study consisted of 54 European Americans, five First Nations/Aborginal, 11 of Asian decent, and two described as "other." Five counselor behaviors were found to have moderate to strong correlations in predicting therapeutic alliance strength. These behaviors were: asking questions, making encouraging comments, identifying and reflecting back the client's feelings, making

positive comments about the client, and validating the client's experience (Duff & Bedi, 2010). Validating a client's experience was encouraged to take place frequently, especially during the early stages of the counseling process (Duff & Bedi, 2010). Physical attending factors were also found to have a moderate to strong correlation with therapeutic alliance. These factors consisted of making eye contact, greeting the client with a smile, sitting still without fidgeting, and facing the client (Duff & Bedi, 2010). The authors suggested that these behaviors may be effective because they demonstrate a sense of focus and attention on the client by the counselor. The authors also suggested that clients may interpret certain behaviors, such as providing positive comments or smiling at the client, as signs that the clinician likes the client. The client thus may experience positive regard through his or her interpretation of these actions. Clinicians' behaviors, such as discussing their personal experiences, having the client choose what to discuss, and using verbal prompts, were not correlated with therapeutic alliance (Duff & Bedi, 2010).

Therapeutic alliance has been demonstrated to have an impact on the client's impression of improvement through treatment, session helpfulness, and client's engagement in treatment (Hayes, Hope, VanDyke & Heimberg, 2007). Hayes et al. (2007) sought to observe this relationship in clients with social anxiety disorder. Their study consisted of 18 adult clients with a mean age of 38.78 years; 13 of the participants had a college education. In regards to clinical improvement in treatment, the authors found that observer-rated alliance had a stronger correlation than client-rated alliance. They also found that clients who experienced difficulties with developing relationships,

such as those diagnosed with social anxiety disorder, could form a strong working alliance with a clinician. A positive correlation was discovered between clients who reported a strong therapeutic alliance with their clinician and their impression of session helpfulness (Hayes et al., 2007). Interestingly, clients with moderate levels of therapeutic alliance along with moderate levels of observer alliance had the highest anxiety ratings in the beginning of treatment and experienced the most change in anxiety. The authors suggested that these clients may have a fear of negative evaluation by the clinician, but may still trust him or her enough to take part in exposure work (Hayes et al., 2007).

Martin et al. (2000) conducted a meta-analytical investigation of the relationship that therapeutic alliance has on treatment outcomes. The authors found that therapeutic alliance does have a moderate relationship to treatment outcome. The authors also found that regardless of the intervention used, a client will regard a relationship as therapeutic if therapeutic alliance has been established.

Antoniou and Cooper (2013) investigated through a meta-analytic study design the significance of the quality of therapeutic alliance on successful treatment outcomes in clients with eating disorders. The authors found that in regards to anorexia nervosa, positive therapeutic alliance had been found to be a likely significant predictor of positive treatment outcomes. The authors stated that the impact of the therapeutic alliance on the treatment of clients with bulimia nervosa was unclear. Although a positive association existed between therapeutic alliance and treatment outcome in psychological care of clients with anorexia, Antoniou and Cooper (2013) also stated that the reasons behind the relationship are not clear. The authors stated that the strength of the therapeutic

relationship not only may stem from the relationship with the therapist, but also may be reflective of parental therapeutic alliance.

**Gender and Ethnic Minority Status**

Gender differences have been found in regards to therapeutic alliance. A study of 600 adolescent patients (81% male, 19% female) with substance abuse issues recruited from four different outpatient sites, found that adolescent female clients typically rated therapeutic alliance higher in comparison to the ratings of male clients (Wintersteen, Mensinger, & Diamond, 2005). Male clients have been found to have a different perspective on the formation of therapeutic alliance. Bedi and Richards (2011) investigated the different factors that male clients value in the therapeutic alliance in a study of 34 men who were currently undergoing psychotherapy. The four variables that were found to be the most significant were bringing out the issues, client responsibility, formal respect, and practical help. Some of the aspects rated under "bringing out the issues" referred to a clinician's attempts at summarization, providing suggestions, confrontation/challenging, and asking about goals. Bedi and Richards (2011) found "bringing out the issues" to be the most significant category. "Client responsibility" also was found to have particular relevance with men; choosing a professional for help, utilizing learned information, and responding to the practical help that is provided fell under this category (Bedi & Richards, 2011). "Formal respect" consisted of such activities as pleasantly greeting the client, taking into account the client's impressions of the office setup, and recognizing the client (Bedi & Richards, 2011). The variable of "practical help" consisted of such aspects as the clinician teaching the client skills,

following through with what was said, making appropriate referrals, and assigning and reviewing homework. The other variables that were identified, but were not as significant, were nonverbal psychoclinician actions, emotional support, office equipment, information, and choice of psychotherapist (Bedi & Richards, 2011).

Clients may experience therapeutic differences and a preference in regards to a therapist's gender. Gehart and Lyle (2001) explored the clients' experience of gender in therapeutic relationships. The authors qualitatively studied the different experiences of 15 clients (7 female and 8 male) in the age range of 13 - 53 years who worked with both male and female therapists. Gehart and Lyle (2001) discovered that across all the subjects, the styles of the male and female therapists were clearly different. The male therapists were more direct and problem focused, but only half of the sample found these traits helpful. The clients also reported that the female therapists had a greater focus on feelings, which also resulted in only half of the subject population finding that quality helpful. The authors stated that these findings are consistent with the gender stereotypes of male individuals as oriented toward problem solving oriented and female individuals as caring. Note that the authors warned against making broad generalizations of the findings because of the small sample size.

In regards to a client having a preference towards clinician gender, women were more likely to express a preference (Stamler, Christiansen, Staley, & Macagno-Shang, 1991). In a sample of 350 female and 150 male clients undergoing an intake interview in a university setting, male clients typically requested a male counselor if the intake counselor was male. However, female clients typically requested a female counselor

when provided an option regardless of the gender of the intake counselor (Stamler et al., 1991).

Some support for gender preference was also discovered by Johnson and Caldwell (2011) when exploring the preference of race and gender in marriage and family therapy with 233 clients (137 female, 94 male) in a university setting. The authors discovered that satisfaction between clients and therapists was greater when matched only on gender; however, this finding was not found to be significant when other variables were taken into account. The authors also discovered that race matching did not impact therapist or client satisfaction.

Certain approaches may be beneficial for improving therapeutic alliance with ethnic minority clients. Vasquez (2007) recommended that clinicians who practice from a cognitive-behavioral theoretical foundation take into account the possible effect that racism or oppression (if present) may have had on the client's ability to achieve his or her goals. Vasquez (2007) suggested that racial stress management can be a beneficial part of treatment for those who have experienced oppression. A clinician should be aware of the stance that he or she takes during the session in terms of appearing authoritarian, egalitarian, or nondirective (Vasquez, 2007). Clinicians should continuously assess their interaction styles to ensure that they do not hinder the relationship with certain culturally diverse clients (Vasquez, 2007). Vasquez (2007) also suggested that the clinician utilize a variety of interventions and respect the needs of the client in order to be more culturally sensitive. Self-awareness, cultural knowledge, and knowledge of evidence-based treatment with ethnic minority populations are qualities that the clinician should possess

in order to develop better therapeutic alliance with his or her clients (Vasquez, 2007). The most important aspect in promoting a healthy therapeutic alliance is for clinicians to be aware of their own attitudes (Vasquez, 2007). Clinicians should be aware of their own biases and develop an ability to promote knowledge, attitudes, and skills regarding the cultural background of the clients they treat (Vasquez, 2007).

**Culture and Therapeutic Alliance**

A client's perception of a clinician's MCO can impact the working alliance, real relationship, and psychological functioning (Owen et al., 2011). In investigating this impact, Owen et al. (2011) found that the client perception of MCO is, in fact, shown to positively impact a client's psychological well-being. The authors' sample consisted of 176 university counseling clients, in which 136 were women, 38 were men, and two were transsexual men. The authors also discovered that a client's perception of a clinician's MCO was positively correlated with working alliance. An important finding was that the alliance between the client and clinician served as a mediator for the client's perception of the clinician's MCO and his or her psychological well-being (Owen et al., 2011). Clients' views of a clinician having effective multicultural competency can positively impact the clients' perceptions of the clinician's credibility (Owen et al., 2011). The development of a strong therapeutic alliance can also lead to improvements in the client's psychological state (Owen et al., 2011). The authors suggested that the creation of a strong therapeutic alliance sets the stage for a clinician and a client to manage cultural issues (Owen et al., 2011). They also discovered that being able to discuss cultural issues in session leads to an authentic connection with clients (Owen et al., 2011).

In summary, therapeutic alliance has been demonstrated to be an essential facet of the therapeutic relationship and in treatment outcomes. Therapeutic alliance not only has been shown to improve treatment outcome, but also has been shown to impact attrition. A clinician must be able to utilize therapeutic alliance techniques in order to improve alliance and to decrease attrition. This approach can have a significant impact across a variety of settings, including cross-cultural treatment settings.

## Attrition

Approximately 23 million Americans receive mental-health services each year (Olfson & Marcus, 2010). However, a large number are unable to complete the recommended treatment course of psychotherapy. This phenomenon is called attrition or client dropout and hinders the delivery of mental-health services across a variety of settings and populations (Barrett et al., 2008). Attrition is a problem that psychologists and counselors face in their efforts to treat clients. A review of client attrition in the psychotherapy literature has shown alarming statistics. In an effort to determine the current rate of dropout and its predictors, Swift and Greenberg (2012) reviewed 669 studies that included 83,834 clients. The authors found that the average dropout rate in adult psychotherapy was 19.7%. Swift and Greenberg (2012) reported that treatment orientation and delivery of therapy (individual vs. group therapy) did not impact this rate. In looking at depression alone, researchers discovered that remission of depression is less likely in the groups that dropped out of treatment regardless of income levels (Warden et al., 2009). Attrition prevents clients from achieving recovery, wastes limited mental-

health services, increases waiting-list times, and creates a financial burden on mental-health services (Barrett et al., 2008).

**Correlates of Attrition**

Research indicated that dropout is significantly correlated with social class variables, such as minority racial status, low education level, low socioeconomic status, and income rates (Warden et al., 2009). Warden et al. (2009) investigated these factors through the review of the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study, which consisted of 4,041 adults between the ages of 18 - 75 years in an outpatient setting. The participants in the analytic sample consisted of 76% European Americans; 18% African Americans; and 6% Asian, other race, or multiracial. Income was shown to have a negative correlation with attrition, and Warden et al. (2009) suggested that this correlation might result from the added daily demands that those with a lower income may experience. Regarding those in the lowest income group, predictors of higher attrition included less education, better mental-heath functioning, being on public assistance, and having an Axis I diagnosis (Warden et al., 2009). Predictors of higher attrition in the middle-income group included less education, better mental-health functioning, being of a non-White race, and receiving treatment in a psychiatric rather than a primary-care setting (Warden et al., 2009). Predictors of higher attrition in the highest income group included being Hispanic, having a family history of drug abuse, and having melancholic features (Warden et al., 2009). Warden et al. (2009) found age to be an independent predictor as well, in that the younger the client, the more likely he or she was to drop out of treatment. The authors also found that education was a factor in

predicting attrition. A client with a higher level of education (15.2 years) was found to be less likely to drop out of treatment in comparison to a client with a lower level of education (13.8 years or 12.2 years).

Arnow et al. (2007) investigated dropout rates among an outpatient population with chronic depression, and found similar results to those of Warden et al. (2009). In a study consisting of 681 randomized participants in an outpatient setting with 65% of the completers being female and 35% male, Arnow et al. (2007) found that clients in an ethnic or racial minority group (34% dropout rate) were more likely to prematurely drop out of treatment for depression in comparison to European American clients (22% European American dropout rate). The authors also found that younger age, lower income, and having comorbid anxiety disorders were also significant predictors of client dropout (Arnow et al., 2007).

Other factors also have been found to correlate with client dropout. Rapport has demonstrated to be a factor that impacts client attrition. Beckham (1992) found that rapport between the client and the clinician was positively correlated with a client's desire to remain in treatment. Gender has been found to correlate with a higher likelihood of patient dropout in certain settings. King and Canada (2004) examined predictors of patient dropout between male and female clients in a substance abuse outpatient program. Their study consisted of 128 participants (51% female, 49% male) in a specialty outpatient clinic. In regards to gender, the authors found that female gender was a significant predictor of patient dropout. The authors discovered that female patients had a 69% chance of not attending five or more sessions of therapy in

comparison to a 26% chance for men. Occupation and income also have been found to have a correlation with client dropout (Werner-Wilson & Winter, 2010). Werner-Wilson and Winter (2010) investigated these factors in a study consisting of 106 clients in an outpatient setting, in which 53 were male and 53 female. The authors found that those in managerial and service-orientated jobs had the highest likelihood of dropping out of treatment. The authors stated that this correlation may result from the impact the type of occupation has on scheduling. In regards to income, clients in the income range of $25,000 to $30,000 were found to have the most significant level of dropping out of treatment (Werner-Wilson & Winter, 2010). Werner-Wilson and Winter (2010) also found past therapeutic experiences to be a factor in client attrition. Clients who had never had therapeutic experience were found to be more likely to drop out of treatment in comparison to those with therapy experience. Werner-Wilson and Winter (2010) expected that couples would be less likely to drop out in comparison to families or individuals because women reported higher alliances in couples therapy. However, they discovered that couples were more likely to drop out of treatment in comparison to those in family or group therapy (Werner-Wilson & Winter, 2010). The authors suggested that this finding is indicative of factors outside of the therapeutic alliance impacting treatment dropout.

A client's role expectancies have also been shown to be a factor in predicting attrition. Role expectancies are understood as the expectations that occur within therapy, and should not be confused with therapeutic outcome expectations (Aubuchon-Endsley & Callahan, 2009). The client's expectations before starting therapy are crucial to the

therapeutic process, and shifting those expectancies to meet real therapy has been found to be important (Reis & Brown, 2006). Aubuchon-Endsley and Callahan (2009) sought to examine whether a relationship exists between role expectancies and client drop out. The authors investigated this potential relationship in a traditional outpatient setting with 53 participants, of whom 56.6% were female and 82.7% were European American. One scale that the authors utilized was the Psychotherapy Expectancy Inventory-Revised (PEI-R), which focuses on the factors of approval seeking, advice seeking, audience seeking, and relationship seeking. A five-factor model of the PEI-R also focuses on impression seeking. The authors found that those who had scored outside the normative range for these factors were seven times more likely to prematurely terminate treatment. Role expectancies have been demonstrated to be factors that can be measured as early as the first session of treatment. A greater understanding of these factors can help address role expectancy issues and possibly avoid premature dropout.

Race also has been demonstrated to be an important factor that contributes to client attrition. Following an intake, race has been shown to be a factor that impacts a client's return to treatment, regardless of the treatment problem (Sue & McKinney, 1975). African American clients were found to be much less likely to return for treatment in comparison to European American clients after an intake session (Levy, Thompson-Leonardelli, Smith & Coleman, 2005). Historically, Asian Americans had been found to have a higher dropout rate (52%) in comparison to European Americans (29.8%) and were seen for fewer sessions by the counselors than were the European American clients (Sue & McKinney, 1975). However, insufficient recent research

disallows consideration of whether this statistic is still valid today. Finally, in a substance abuse treatment setting, African American youths were found to be more than twice as likely as Hispanic youth to prematurely dropout of treatment (Austin & Wagner, 2010).

Age has also been demonstrated to be a factor that correlates with attrition. Mancino et al. (2010) conducted a nationwide analysis of the predictors of attrition with veterans in methadone maintenance treatment. The study consisted of 2,363 patients across 23 Veterans Administration medical centers, with the mean age being 48.2 years and 95.2% of the population being male. The authors discovered three main factors that were associated with high dropout rates in methadone maintenance; younger age, being of African American race, and having serious mental illness (Mancino et al., 2010). Arnow et al. (2007) also discovered that clients of a younger age are more likely to prematurely drop out of treatment. Age must therefore be taken into consideration by the clinician in assessing possible reasons for a client's discontinuation of treatment.

**Correlates of Treatment Retention**

The race of a clinician has been demonstrated to have an impact on treatment retention. Wintersteen et al. (2005) investigated the impact of gender and racial differences on therapeutic alliance and attrition in a study of 600 adolescent patients (81% male, 19% female). The authors found that European American clinicians, when compared to clinicians from all other racial categories, had a significantly higher dropout rate when treating minority clients. Only 48% of minority clients completed two thirds of the treatment, in comparison to the 79% of European American clients with European

American clinicians. This study also found that 66% of European American clients treated by minority clinicians completed two thirds of the program (Wintersteen et al., 2005).

Culturally sensitive training has shown to decrease attrition through its positive impact on clients' perception of counselors (Wade & Bernstein, 1991). In a study consisting of four European American and four African American counselors treating 80 African American patients, Wade and Bernstein (1991) found that cultural competency training of counselors resulted in higher retention rates of African American female clients as compared to clinician–client race matching without cultural-competency training. The counselors who received the training were found to have higher ratings of expertise, trustworthiness, attractiveness, unconditional regard, and empathy in comparison to the counselors without the training. The clients of the culturally trained counselors also were found to return for more follow-up sessions and had a greater satisfaction with the counseling process (Wade & Bernstein, 1991). The training influenced the clients' perceptions of both African American and European American counselors. The authors also found that the perception of the counselor begins to develop during the first session and remain consistent during the second and third sessions. Wade and Bernstein (1991) suggested that African American female clients may therefore experience a decisive perception of the counselor in the initial session.

Specific individual factors have demonstrated to predict treatment retention also in the youth population. In an archival study of 447 children (29.2% male) with a mean age of 11.87 years, ethnicity and client symptom severity demonstrated to be two

significant predictors of client dropout (Miller, Southam-Gerow, & Allin, 2008). In regards to ethnicity, the authors discovered that children of European American families were more likely to complete a greater number of sessions than children of non-European American families. Miller et al. (2008) argued that this finding may have been the result because the majority of clinicians were of European American descent, thus leading to a lack of culturally matched client-clinician pairs. They also found that clients with an Axis I Adjustment Disorder and no Axis IV stressors at intake received fewer sessions than did clients with a differing Axis I diagnosis that had an Axis IV stressor (Miller et al., 2008). The authors argued that this finding may reflect that the youths who are in the most need of services receive the most care.

In summary, attrition in therapy has demonstrated to be a problematic issue in a variety of settings across populations. However, evidence shows that a clinician can take steps towards decreasing attrition. Specifically, in regards to cross-cultural therapy, a clinician's ability to appropriately work with clients of different cultures has been shown to combat attrition (Wade & Bernstein, 1991). Training in working with various cultures is therefore essential to the appropriate treatment of culturally diverse clients.

## Culture

Culture is reviewed broadly in this study and can be conceptualized in different ways. Cohen (2009) described culture in terms of religious orientations and practices, region, and SES and examined the different aspects that define culture. Cohen (2009) defined a culture as a, "socially transmitted or socially constructed constellation consisting of such things as practices, competencies, ideas, schemas, symbols, values,

norms, institutions, goals, constitutive rules, artifacts, and modifications of the physical environment" (p.195). This definition allows for culture to take various forms. Religion, for example, can serve as a defining feature of culture. Within religious cultures are many important differences that need to be considered in terms of beliefs, practices, and traditions (Cohen, 2009). SES and social class also fit into the definition of a culture (Cohen, 2009). Cohen (2009) also discussed the cultural impact of the region of the country. Based on region, people can differ in their values and norms. These differences can be witnessed through individualistic versus communal cultures (Cohen, 2009). The American Psychological Association (2003) also described how culture can be viewed as a way of living that is informed by historical, economic, ecological, and political forces. The association suggested that culture is a fluid and dynamic concept that has both cultural-specific and universal aspects (American Psychological Association, 2003).

Multicultural competence is an ethically important skill for clinicians to possess. Brown and Pomerantz (2011) sought to evaluate whether multicultural incompetence can be viewed as an unethical behavior through a vignette study with 174 undergraduate students (66.1% female, 33.9% male). In order to measure this theory, the authors provided participants with vignettes depicting situations in which a clinician committed either a culturally based violation or a noncultural violation. The culturally based violations included actions that were "insensitive, ignorant, prejudicial, or otherwise inappropriate responses to some aspect of client's culture (one per vignette): race, gender, religion, socioeconomic status, age, or sexual orientation" (Brown & Pomerantz, 2011, p. 501). The noncultural violations included "sexual multiple relationships, nonsexual multiple relationships, breeching confidentiality, practicing outside the bounds of

competence, practicing while impaired, and mishandling of interruption of services (vacation)" (Brown & Pomerantz, 2011, p. 501). Following the vignette, the participants were asked to answer a set of questions related to client dropout, perception of the therapists' ethicality, the impact of the behavior on the client, and the likelihood that the participant would see a therapist who was similar to the therapist in the vignette. The results indicated that overall participants viewed both the cultural violation situations and the noncultural violation situations as equally unethical actions (Brown & Pomerantz, 2011). The authors concluded that these results indicate that multicultural training is equally as important as general ethical behavior in treatment. They made the point that potential clients may have an impression of the impact of multicultural competence prior to the start of treatment and of how it relates to the therapeutic relationship (Brown & Pomerantz, 2011). Participants also indicated that they were more likely to discontinue treatment if the therapist demonstrated poor multicultural competence and that they would not recommend the therapist to others. These results further represent the value of multicultural competence to the perception of clients and also reflect the need for multicultural competency to be viewed as an ethically necessary part of clinical training.

Focus on certain factors has been found to be important when treating clients from ethnic and minority cultures. The ADRESSING model addresses nine cultural factors found to be in need of attention by the counselor and brings attention to their related minority groups and forms of oppression (Hays, 1996). These nine factors are age/generational, disability, religion, ethnicity/race, social status, sexual orientation, indigenous heritage, national origin, and gender. The ADRESSING model leads counselors to a heightened awareness of their own biases/inexperience, and to a consideration of the impact of cultural influence on clients who are of a cultural minority

(Hays, 1996). One way that addressing counselor bias can take place is by counselors asking themselves how their identity fits into the model (Hays, 1996). The model also stresses the importance of deepening the counselor's awareness of the racism and ethnocentrism that some clients experience. The model also asks counselors to challenge their biases through the consideration of an ethnic identity through the factors of the model. The goal of this method is to reduce the generalization that sometimes takes place (Hays, 1996).

Acculturation is a process that people experience when immigrating to another culture. Mio, Barker-Hackett, and Tumambing (2006) described acculturation as the "experiences and changes that groups and individuals undergo when they come into contact with a different culture" (p. 129). The authors discussed the different types of acculturation experiences that immigrants may experience based on models by previous researchers. Among those models is Berry's model of acculturation, which consists of the assimilationist perspective (giving up one's identity in favor of the new culture), the separationist perspective (maintaining identity of origin and rejecting new culture), the marginalist perspective (not identifying with either new or original culture), and the integrationist perspective (integrating aspects of the new and original culture; as cited in Mio et al., 2006). An understanding of these experiences may certainly be beneficial in working with immigrant clients.

Also of importance is taking into account the acculturation experience of immigrants who are taking part in mental-health services. Sánchez et al. (2014) interviewed 250 people, including Puerto Rican adults ($n$ = 50), Latino immigrants ($n$ =

75), and Brazilians ($n$ = 125) in Massachusetts in order to examine the impact that acculturation (adopting values and behaviors of another culture) and stigma had on their reporting of mental-health symptoms and seeking of services. The authors specifically focused on individuals with depression and anxiety diagnoses. Acculturation was significantly associated with treatment seeking among Brazilians. The more acculturated Brazilians demonstrated a significantly greater tendency to endorse seeking out anxiety treatment than did the less acculturated. This group was also found to be more likely than acculturated Puerto Ricans to seek treatment for anxiety disorders. The authors also did not find stigma to be associated with treatment seeking for symptoms of anxiety and depression.

Yoon et al. (2013) conducted a meta-analysis of 325 studies investigating the relationship between acculturation/enculturation and mental health. The authors found that acculturation of language, identity, and behavior were positively correlated with positive mental-health characteristics, such as self-esteem, life satisfaction, and positive affect. The authors found that a mix of external acculturation behaviors along with internal enculturation is associated favorably with mental health. Interestingly, Yoon et al. (2013) found the level of importance of acculturation/enculturation varied by race. The authors found that Asian Americans valued acculturation behaviors, whereas African Americans placed more value on enculturation (retaining characteristics of the culture of origin).

Arthur Nezu (2010) brought to light interesting dynamics to consider through his reflection on his experience as a Japanese American psychologist working in America.

In his reflections, Nezu (2010) made the important point that therapists must realize that they act as a stimulus for a client. Whether this action takes place through physical characteristics, clothing, or room décor, therapists must recognize that their clients may be responding in a variety of ways to their presentation. Through self-reflection on his diversity and how it impacted his clients and himself as a therapist, Nezu provided general guidelines aimed at enhancing the therapeutic relationship while embracing diversity and culture (Nezu, 2010). The first guideline is that "diversity does not equal biological determinism" (p. 174). One must not mistake genetic makeup for psychosocial or intelligence-based characteristics (Nezu, 2010). The second is to "respect subcultural diversity" (p. 174). Not all members of a cultural group act the same, and the therapist must ask questions regarding the client's background and its meaning to the client (Nezu, 2010). The third is to "be sensitive to all differences" (p. 174). Nezu discussed how any difference can be perceived as important, and he recommends taking the Hays' (1996) ADRESSING model into account (Nezu, 2010). The fourth guideline is to "inquire about a variety of diversity characteristics" (p. 175). Identifying diversity characteristics and how they impact each other is important (Nezu, 2010). The fifth is to "inquire about the meaning of diversity for a given client" (p. 175). The therapist must respect and inquire about how a client views his or her own diversity status (Nezu, 2010). The sixth guideline is to "understand the politics of a client's diversity status" (p. 175). Nezu makes the point that the therapeutic relationship can have political overtones, and the therapist must be cognizant of how a client's diversity status may be connected with prejudice, discrimination, and minimal political influence (Nezu, 2010). Therapists

should ask their clients how they feel about themselves as a possible therapist (Nezu, 2010). The final guideline that Nezu offers is to "become more 'involved'" (p. 175). Nezu discusses the importance of involving oneself in activities that promote cultural competency, such as being up to date on the literature related to advancing ethnic minority interests (Nezu, 2010).

**Cross-Cultural Therapy**

An important aspect of cross-cultural and cross-racial psychology is an understanding of the client's perception of therapy. Chang and Berk (2009) researched the factors that facilitate the success or failure of cross-racial therapy. Their study was qualitative and consisted of 16 participants, of whom eight were men and eight were women. The participants were matched to a gender and, in most cases, race/ethnicity control or experimental group. Sixteen ethnic-minority patients received treatment from 16 European American therapists. In terms of race, the participant population consisted of three Asian, six African American, five Latino, and two multiracial persons. Chang and Berk (2009) found that one key factor in understanding the client's perception of therapy is to take into account the evaluations made by the client. These evaluations can provide information on the level of therapeutic alliance and on whether the direction in the relationship between the client and the clinician is clear (Chang & Berk, 2009). The authors also found that satisfied clients viewed the clinician as having such characteristics as being caring, respectful, accepting, congruent, and responsive to the client's needs (Chang & Berk, 2009). Self-disclosure has also shown to be an aspect in client satisfaction. Self-disclosure is a tool that the clinician can utilize to help reduce the

perception of a power differential that inherently may exist in therapy (Chang & Berk, 2009). Self-disclosure does not need to be intimate to be effective, in that general self-disclosure, such as talking about places lived, has been found to be effective as well in cross-racial therapy (Chang & Berk, 2009). Another important aspect of cross-racial therapy is the correction of issues in the therapeutic relationship. The healing of the therapeutic alliance has shown to have positive outcomes in treatment and involves utilizing effective communication primarily in the form of productive negotiation (Chang & Berk, 2009).

Certain context-specific approaches have been found to be effective in cross-racial therapy. The majority of minority clients in cross-racial therapy were found to have key expectations of their clinicians (Chang & Berk, 2009). A significant number expected their clinicians to offer expert guidance and advice and to give specific instructions as to achieving goals. Directive clinicians were viewed as more helpful and engaged in comparison to those with a less directive approach (Chang & Berk, 2009). Clinicians who had specific knowledge of a client's culture and had skills in dealing with cultural dynamics were also valued. A clinician's ability to understand the impact that culture and race have on a client's identity, along with an ability to provide criticism for cultural ignorance, has also been found to be effective in cross-racial therapy (Chang & Berk, 2009). Asnaani and Hofmann (2012) discussed the value in adapting the majority of the treatment process to make it more culturally relevant to the client. The adaptations would take place during the intake, intervention, and termination. The authors discussed the importance of incorporating the client's "culture-specific skills" (Asnaani &

Hofmann, 2012, p. 190) into the treatment. These skills may include coping mechanisms (e.g., metaphors specific to culture), community resources (e.g., places of worship, social causes), artistic outlets (e.g., dance, music), and specific cultural skills (e.g., cooking, fishing; Asnaani & Hofman, 2012). Adapting the session to the client involved weighing in group, religious, and spiritual beliefs (Asnaani & Hofman, 2012). The authors discussed a client's reaction to this culturally tailored treatment, stating that the client reported "feeling respected, listened to, and entrusted in contributing to her own progress, which gave her confidence in continuing the skills on her own after therapy had ended" (Asnaani & Hodman, 2012, p. 195). In regards to unsatisfied clients, a lack of cultural competence was found to be a significant factor in a client's belief regarding the cause of a failed therapeutic relationship (Chang & Berk, 2009). Developing cultural competence and appropriately discussing culture in therapy have been demonstrated to be essential therapeutic skills in cross-cultural therapy.

Reviewing a clinician's multicultural competency from the perspective of a client is of great value. Moleiro, Freire, and Tomsic (2013) investigated the multicultural competencies of clinicians from the perspective of ethnic-minority immigrant groups in Portugal. The authors investigated these competencies across 40 adult participants (30 female, 10 male) across eight different focus groups. In reviewing the past experiences of the participants, the author's found that all the participants had at some point experienced discrimination in their healthcare system, and those who had previous mental healthcare reported mixed reactions. The authors found that these clients defined a clinician's multicultural competency as

being comfortable with cultural differences; being aware of the client's

> background and its influence on psychological processes; being aware of one's own stereotypes and negative emotional reactions towards groups and clients; respecting indigenous helping practices and community networks; respecting a client's religious and spiritual beliefs; and valuing multilingualism. (Moleiro et al., 2013, p. 92)

Clients also valued a clinician who had specific knowledge of the client's culture, family structure and communities, and of the impact of culture and linguistic features on delivery of psychological treatment (Moleiro et al., 2013). The authors also found of importance clinicians' knowledge of various cultural perspectives that a client may experience, such as "acculturation processes; prejudice and racism; how race and ethnicity impact personality formation and manifestations of distress; the role of sociopolitical variables, immigration, poverty, and powerlessness; and to know how to recognize institutional barriers to mental healthcare" (Moleiro et al., 2013, p. 93). The authors expressed that clinicians would benefit from developing multicultural skills that focus on the impact of immigration status on a client, incorporating cultural aspects into treatment, eliminating discrimination from the workplace, providing linguistic services for the client, taking part in continuous education/training, seeking consolation and services, and advocating for clients (Moleiro et al., 2013).

The perspective of European American clinicians who work with racial minority clients may also be helpful in identifying the factors that impact the therapeutic relationship. Singer and Tummala-Narra (2013) investigated the perspectives of 13 European American clinicians (six male, seven female) who worked with clients of racial-minority immigrant origin through the use of a qualitative research approach. The authors sought to identify the potential barriers and successes that contribute to

therapeutic care that is culturally competent (Singer & Tummala-Narra, 2013). The authors were interested in obtaining information on the feelings, thoughts, and reactions of clinicians to the worldview of their clients (Singer & Tummala-Narra, 2013). Singer and Tummala-Narra (2013) were also interested in the clinicians' perspective on the therapeutic relationship and on their own self-exploration of multicultural issues. Based on their data, the authors discovered that three domains emerged: "(a) engagement with multicultural issues, (b) perceptions of the client's experiences, and (c) experiences of the therapeutic relationship" (Singer & Tummala-Narra, 2013, p. 293). In regards to clinicians' engagement with multicultural issues, four subthemes emerged that included clinicians' approaches to learning about multicultural issues, clinicians' views on whether race and ethnicity are important factors in psychotherapy, clinicians' self-perceived limitations and strengths concerning multicultural competence, and clinicians' reflections on multicultural issues (Singer & Tummala-Narra, 2013). In reviewing the perceptions of the clients' experiences, responses focused on the systematic factors that impact clients (immigration status, SES, familial stress), the way clients approach counseling, and navigating cultural divides (Singer & Tummala-Narra, 2013). The review of the experiences regarding the therapeutic relationship revealed concerns of barriers and facilitating factors that impact the therapeutic relationship, the therapist addressing sociocultural differences with clients, and reflections on the role of the therapist in the therapeutic relationship (Singer & Tummala-Narra, 2013). Overall, the participants in the study focused on the importance of developing a collaborative and empathic relationship with their clients (Singer & Tummala-Narra, 2013).

Matching clinicians and clients based on racial and ethnic culture has not demonstrated to be an effective approach in increasing therapeutic alliance. Cabral and

Smith (2011) sought to examine the effects of racial/ethnic matching by focusing on three factors: "(a) preferences for clinicians of individuals' own race/ethnicity, (b) perceptions of clinicians across racial/ethnic matching, and (c) outcomes in therapy as impacted by racial/ethnic matching" (p. 540). The authors conducted a meta-analysis study design across 52 studies of preferences and expected that therapeutic alliance in racial/ethnic matched treatment would increase therapeutic alliance because of the similarities between the client and the clinician. However, their results demonstrated that treatment outcomes did not differ based on the client and clinician being of the same race/ethnicity. According to the authors, clients generally prefer clinicians of the same race/ethnicity, but once therapy is in effect, the factor of race/ethnicity does not play a role. The authors did, however, find that African Americans strongly preferred to be matched to African American clinicians and would evaluate them more positively than other clinicians. Cabral and Smith (2011) expressed that evaluation may be the result of a strong racial/ethnic identification and a wariness regarding the bias that European American clinicians may have. The findings of Cabral and Smith (2011) demonstrate that cross-cultural therapy can produce treatment outcomes that are comparable to same-culture treatment. The authors discussed the importance that clinician skill and disposition can have on treatment outcomes in light of racial and ethnic matching. The finding that clients prefer clinicians of the same race cannot be ignored, however. Therefore, clinicians in cross-cultural therapy must be aware of this preference and be able to address any perceptions or issues that clients may experience in the early sessions of therapy. One should also note that matching clients based on race and gender in a substance abuse treatment setting did not lead to a decrease in early dropout rates (Sterling, Gottheil, Weinstein, & Serota, 1998).

Language is another factor that must be considered in cross-cultural therapy. In counseling Asian American clients who speak little to no English, language can act as a barrier and can lead to misunderstandings between the client and the clinician (Leong, 1986). Regarding the Hispanic community, Biever et al. (2002) found a need to train clinicians to provide services in Spanish. The authors expressed that interviewing clients in a language other than their dominant language may limit what they are able to say (Biever et al., 2002).

Cross-cultural therapy contains issues in treatment that are not as salient in same-culture therapy. Fortunately, research has been conducted that demonstrates effective techniques a clinician can utilize in cross-cultural therapy (Chang & Berk, 2009). Most importantly, cultural competence has been shown to be an area that is of significance in a client's view of why therapy may have failed. Cultural competency, therefore, is essential to understanding why a client may discontinue treatment and to better understanding attrition in cross-cultural therapy.

**Cultural Identity**

Cultural identity can be understood as one's self-identification and self-definition as they relate to them as being part of a cultural group (Schwartz, Montgomery, & Briones, 2006). It also relates to how one identifies oneself with an ethnic group or nation. Schwartz, Zamboanga, Rodriguez, and Wang (2007) discovered three primary dimensions of cultural identity: (a) American-culture identity, (b) heritage-culture identity, and (c) biculturalism. These dimensions have been found across European Americans, African Americans, and Hispanics (Schwartz et al., 2007). Biculturalism is understood as the unique blending of cultural components from both the national and

receiving cultures (Benet-Martinez & Haritatos, 2005). Schwartz et al. (2007) also found that the inclusion of the receiving culture into one's identity does not take away from one's endorsement of the homeland culture.

Immigrants have a unique experience in regards to the development of cultural identity. Immigrants have been found to appraise their two countries somewhat independently (Tartakovsky, 2009). The attitudes that immigrants experience towards their receiving country are not impacted by their attitudes towards or sense of belonging to their homeland (Tartakovsky, 2009). Although immigrants are able to experience a sense of belongingness to both countries, Tartakovsky (2009) also found that immigrants typically experience a stronger sense of belongingness to one country, while experiencing a less positive attitude towards the other.

Third-culture individuals are defined as those who lived outside of their native country during their developmental years (Moore & Barker, 2012). Moore and Barker (2012) investigated the way the intercultural experiences of third-culture individuals have impacted their sense of identity, sense of belonging, multiculturalism, and intercultural communication competence. The authors' study involved 11 women and eight men whose ages ranged from 18 - 44 years. They found that third-culture individuals are more likely to develop a multicultural competence rather than a confused identity. These individuals could be competent in both cultures without sacrificing their cultural identities (Moore & Baker, 2012). The authors found that the intercultural competency, which is defined as the ability to foster multiple cultural identities, of these individuals was also a strength. They noted that individuals in their study were able to shift between

cultural identities without feeling a sense of belongingness to one particular culture (Moore & Barker, 2012).

A clinician needs to have an understanding of the client's cultural identity in order to better understand his or her worldview. The cultural identity of a client may impact the way that a client responds to a clinician's discussion of culture and whether cultural differences become an issue for the client. A clinician should attempt to develop an awareness of the client's cultural identity by choosing to acknowledge racial differences with the client.

**Age**

The age difference between a client and his or her clinician can be an important factor in the client's treatment. The age of the client can act as a powerful factor in the way he or she is perceived by a clinician. In regards to couples and marriage therapy, age has shown to play such a role. Ivey, Wieling, and Harris (2000) sought to measure the effect of age on couples therapy. Their study was conducted with participants who were older (ages 74 and 69 years) and younger (ages 29 and 34 years) than their clinicians. The authors found that in terms of couple functioning, older couples were perceived to have a healthier overall relationship in comparison to younger couples. The authors also discovered that sexual concerns, substance use, and conflict were indicative of a more serious impairment to the relationship of the younger couples in comparison to the older (Ivey et al., 2000). The authors suggested that clinicians may not view these issues as problematic for older relationships. This finding supports the ageist assumption that these issues may be normal for older couples (Ivey et al., 2000). Although focused on

couples therapy, the research conducted by Ivey et al. (2000) demonstrated that the age of the client does play a role in the perception of the clinician and may also impact the focus of treatment.

The typically young age of clinicians can lead to issues in treatment. The majority of clinicians in urban areas have not yet reached middle age, and younger clinicians are usually employed in the clinics and hospitals that the older clients are visiting (Wilensky & Weiner, 1977). Wilensky and Weiner (1977) argued that this age difference may lead to an increase in transference and countertransference resulting from the resemblance of the clients to their parents or grandparents. Wilensky and Weiner (1977) discussed the doubts that older adults may experience about a younger clinician being able to understand their issues and dilemmas, which a clinician needs to be aware of. The authors also investigated the typical problems that older clients experience that are not as salient to the typical young client. Physical pain, a typical problem that is experienced by older adults, requires the clinician to accept the concept of having a limited goal (Wilensky & Weiner, 1977). Clinicians working with this population may also find that the challenges of these clients take place in the routine and repetitive aspects of daily life. The focus of sessions may be on these issues. Some of the most significant factors in working with older clients may be the characteristics of the clinician (Wilensky & Weiner, 1977). Wilensky and Weiner (1977) stated that clinicians need to be aware of speaking to older clients in a condescending manner, which can be communicated by over-politeness or exaggerated warmth and concern. The authors also pointed out the importance of a reluctant clinician to examine the foundations of that

reluctance in order to become more competent in working with older clients (Wilensky & Weiner, 1977).

Age factors impact the therapeutic alliance when adjustments must be made for older clients. Hyer, Kramer, and Sohnle (2004) investigated the altering of CBT for an older population and its impact on therapeutic alliance. The authors pointed out that older clients may respond negatively to common treatment components of CBT. They stated that constantly applying the cognitive model may be unfavorable for this population because older adults may have age-related cognitive deficits that make the application of the model difficult and frustrating. The authors also discussed the negative impact that CBT's emphasis on psychoeducation can have on an older client, especially one who has experienced a loss or displacement (Hyer et al., 2004). The authors also discussed the concern of clinicians being overly rigid in utilizing manuals and protocols and how that rigidity may impact the therapeutic alliance between a clinician and client.

In light of the difficulties faced by older clients, Hyer et al. (2004) discussed four methods by which to alter CBT in order to improve therapeutic alliance with an older population. The first method that the authors suggested is that of socialization with the client. Clarifying the role of the client and therapist, providing education, and working towards engaging the client with the therapeutic process are important from the start of treatment. The first four sessions should incorporate socialization along with the standard CBT didactic information. The authors stated that the therapeutic relationship is moreso the foundation for accomplishing treatment goals with older adults than with younger. The second alteration to CBT is cognitive restructuring and behavioral

activation. Hyer et al. (2004) discussed the difficulty that older adults experience in understanding the relationship between thoughts and behaviors. The therapist must be active and accepting with these clients in this process. The therapist may need to provide additional time for this process and incorporate other techniques (e.g., flip charts, role playing). The therapist must be able to utilize the relationship he or she has with the client when learning appears to be difficult (Hyer et al., 2004). The third alteration relates to the psychological resource building into the context of selection, optimization, and compensation. Various situations in CBT require a therapist to provide a client with resources that are focused on developing healthy coping skills (Hyer et al., 2004). These situations may be problematic to the therapeutic alliance when the therapist experiences resistance to or rejection of their help. The client may not want family included in treatment or may not want to be treated as a "student" (Hyer et al., 2004). In such situations, the authors suggested that the therapist ask the client to identify a problem and the resources that would be needed for change. The therapist should work with the client to help select skills that he or she has already developed to address the issue (Hyer et al., 2004). These can be skills that may not be currently used, but have been in the past. The final alteration that can be made to CBT is in relation to affect tolerance. Clients may feel that they cannot change in therapy because overwhelming emotion. The authors called for the therapist to be aware of the client's emotional/cognitive framework and to be flexible in his or her techniques. Validating emotions is helpful as this process develops and shifts attention to the experience of feeling (Hyer et al., 2004)

Knight and Satre (1999) also discussed the adjustment of CBT in the treatment of older clients. They found that CBT can be adapted to address issues that clients experience later in life. These issues include, but are not limited to, depression, alcoholism, insomnia, physical illness, and disability (Knight & Satre, 1999). The authors recommended that clinicians make efforts to learn about the social environment of these clients (Knight & Satre, 1999). They also suggested that clinicians need to shift their mindset in terms of the problems that older clients experience in comparison to those experienced by their younger clients (Knight & Satre, 1999). Younger clients may experience issues related to misperceptions and faulty thinking, while older clients may experience these issues in addition to those related to physical limitations (Knight & Satre, 1999). Clinicians must adapt to the likelihood that their clients might have a learning history different from their own. Older adults will likely have less education than younger adults, and a clinician needs to consider such in the materials that they utilize in treatment (Knight & Satre, 1999). An especially important factor is the impact of the interplay between the client's psychological and physical factors (Knight & Satre, 1999). Knight and Satre (1999) expressed that the majority of older adults are dealing with issues related to chronic illness. The authors suggested that the goal of CBT in many of the situations related to illness should focus not on making clients happy, but on decreasing their sadness (Knight & Satre, 1999).

Age is a visible cultural characteristic that can be a significant factor in working with clients. It can impact the perception of the clinician and the client, the treatment approach, and the issues that clients bring to therapy. Therefore, the clinician must be

aware of any age-related issues that may be present with a client and of any issues regarding age differences between the client and the clinician. The acknowledgement of these issues may lead to a greater understanding between the client and the clinician.

## Acknowledging Culture in Therapy

Discussing the subject of race, ethnicity, and culture can be difficult for a clinician in the counseling process. However, a clinician broaching the issue of race may provide an opportunity for the client to process any present issues of shame through a safe environment, thereby leading to a more intimate relationship that embraces cultural differences. Day-Vines et al. (2007) defined broaching behavior as "a consistent and ongoing attitude of openness with a genuine commitment by the counselor to continually invite the client to explore issues of diversity" (p. 402). The authors suggested that action could take place in various ways, such as the counselor acknowledging a racial difference and asking for the client's perception of this interaction. Empowering the client can be a result of discussing cultural differences, and should be the result of the clinician merging cultural knowledge and practice. Being aware of the client's reaction to broaching is also important because clients who do not identify their racial identity as a significant part of their identity may reject a clinician's attempt to broach the topic (Day-Vines et al., 2007). A clinician may also encounter emotions of anger or hostility from clients who have a strong affiliation to their race. The authors suggested that this reaction may be based on racial oppression that the client has either directly or indirectly experienced (Day-Vines et al., 2007). A client with a healthy sense of racial identity, however, may respond with appreciation toward the counselor (Day-Vines et al., 2007).

Cultural sensitivity plays a significant role in cross-cultural family therapy. Pakes and Roy-Chowdhury (2007) discussed the importance of a deconstructive approach. The authors utilized a discourse analytic in analyzing three sessions from two families in which the family and therapists were of different cultural backgrounds. This approach proposes deconstructing the assumptions that may be present in cross-cultural therapy and making dilemmas surrounding culture central to the therapeutic experience (Pakes & Roy-Chowdhury, 2007). One aspect of deconstructing cultural issues can involve acknowledging the cultural dilemma that a person is experiencing (Pakes & Roy-Chowdhury, 2007). In working with a client who is having difficulty in transitioning to a new culture, it may be beneficial to relate the troubled position of the client to his or her dilemmas in cultural transition (Pakes & Roy-Chowdhury, 2007). A validating and helpful tone can also be used to better help the client understand how his or her position relates to the complexity that is culture. Pakes and Roy-Chowdhury (2007) stressed the importance of making culture the central topic of cultural issues. Although focused on family therapy, the approach that the authors took centralizes around the concept of the importance of acknowledging culture and bringing it into the forefront of therapy.

Five styles are explored in the act of broaching the topic of race, ethnicity, and culture in treatment (Day-Vines et al., 2007). *Avoidant* is the first style and relates to counselors who take on a race-neutral perspective (Day-Vines et al., 2007). These counselors do not believe that issues related to race are important to address, and they tend to minimize race. The second style relates to the *isolating* counselor (Day-Vines et al., 2007). This type of counselor broaches the topic of race, but in a simplistic and

superficial approach. Broaching the topic may take place in a brief statement during the session. The third type of broaching style is *continuing/incongruent* (Day-Vines et al., 2007). This style consists of the counselor inviting a client to discuss the relationship with regard to issues of race. These counselors may view race through stereotypes and view broaching as a skill. The fourth broaching style is that of the *integrated/congruent* counselor (Day-Vines et al., 2007). This type of counselor is able to broach the topic of race, ethnicity, and culture during a counseling session and also integrate the broaching behavior into his or her personal identity. These counselors broach the topic as part of their routine rather than as a technique. They do not address race through stereotyped characteristics and encourage their client to engage in culture-specific interpretations. The final broaching style is that of the *infusing* counselor (Day-Vines et al., 2007). The infusing counselor and the integrated/congruent counselor have similar styles, with the exception that the infusing counselor integrates broaching as his or her way of life and not just as a component of the counseling process. The infusing counselor has complex comprehension of sociopolitical issues and is committed to assisting clients in overcoming race-related difficulties. These two types of counselors have a strong understanding of sociopolitical issues and are committed to eliminating oppression (Day-Vines, 2007).

Addressing cultural differences in psychotherapy can be useful when certain considerations are examined. La Roche and Maxie (2003) examined the appropriateness of discussing cultural differences with clients and offered specific clinical considerations. The first consideration is that cultural differences are subjective, complex, and dynamic.

A clinician should not assume to know the meaning of noticeable differences in a client and must accept the complexity of cultural differences. The authors suggested that the most salient cultural differences be discussed first. The discussions should be based on the history between the clinician and the client, and on the client's perceptions of difference (La Roche & Maxie, 2003). The authors also suggested that discussing similarities prior to cultural differences may be beneficial. Doing so may assist the clinician in developing an initial rapport and increasing the client's comfort (La Roche & Maxie, 2003). The clinician should also consider the client's level of distress and his or her presenting problem in determining when and if cultural differences should be addressed (La Roche & Maxie, 2003). The authors suggested that the more stable the client is, the more likely he or she will be to discuss cultural differences. When framing cultural differences, they should be addressed as assets that can be helpful in the therapeutic process (La Roche & Maxie, 2003). La Roche and Maxie (2003) make the consideration that a clinician should conceptualize presenting problems and goals by assessing the client's cultural history and racial identity development. They suggested that issues in psychotherapeutic relationships influence the meaning and saliency of cultural differences. Possible cultural issues already in place need to be evaluated prior to the addressing of culture. La Roche and Maxie (2003) suggested that a clinician must have an understanding that the therapeutic relationship takes place within the culture of the external world, in which cultural messages are constantly being provided. The events that take place outside of the session can impact whether a client wants to discuss cultural differences.

La Roche and Maxie (2003) further examined issues that should be considered when addressing cultural differences in psychotherapy. The authors stressed the importance of the clinician's cultural competency in the way that cultural differences are addressed (La Roche & Maxie, 2003). A clinician should explore his or her beliefs and attitudes related to culturally different clients, have an understanding of a client's culture, and trust that his or her clinical strategies will develop over time through experience with diverse clients and education (La Roche & Maxie, 2003). The authors also make a point regarding the impact that the cultural dialogues can have on the client's cultural context (La Roche & Maxie, 2003). Clients who become more aware of their sociocultural contexts may be more empowered to try to influence or transform them. The considerations provided by La Roche and Maxie (2003) demonstrated the value of discussing culture in cross-cultural therapy. The authors expressed that there is no specific method regarding how to acknowledge and discuss culture, but that certain considerations can be made. The authors also expressed that such discussions can have an impact on a client's decision to stay in or terminate therapy.

David Burns (1989) discussed effective communication techniques that may be applied when working with clients of a different culture. He identified three listening skills that are particularly effective for communication: the disarming technique, empathy, and inquiry. In working with clients, a clinician may be able to utilize these listening skills for effective treatment. The skills of the disarming technique, empathy, and inquiry may perhaps be the most appropriate for clinical practice. These techniques will be reviewed from the perspective of a client/clinician relationship. The disarming

technique involves a clinician's ability to find and reflect truth in what the client has said (Burns, 1989). This technique can be utilized even if the clinician does not agree with the client. The empathy technique is made up of *thought empathy* and *feeling empathy*. Both techniques involve the clinician mentally placing him or herself in the client's situation (Burns, 1989). Thought empathy is utilized by paraphrasing the client's words, while feeling empathy is utilized by acknowledging how the client is feeling. The clinician can utilize the skill of inquiry by asking questions that probe to learn more about what the client is saying or feeling, but in a nonthreatening, supportive manner (Burns, 1989). These skills may translate into treatment in terms of validating a client's experience and feelings, showing empathy for that experience, and asking questions to learn more about how the client feels and what he or she experienced.

Many clinicians do not acknowledge cultural differences in cross-cultural therapy, while many other clinicians feel that discussions on race and culture facilitate therapy. However, in regards to cross-cultural therapy, fewer than half of clinicians (42%) report having discussion about cultural differences with their clients (Maxie et al., 2006). The authors suggested that relevant situations in these therapeutic relationships warrant the discussions. They found that there is an equal likelihood that either the clinician or the client would initiate the conversation. Another important finding was that most clinicians discuss feeling comfortable with discussing cultural differences (Maxie et al., 2006). The authors suggested that this finding may be the result of extensive clinical experience and of many clients wanting to initiate the conversations on their own.

Clinicians across disciplines and cultures have had differing experiences and

reactions in regards to their multicultural training. The American Psychological Association (2003) expressed the importance of multicultural education in their publication, "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists." The third guideline addresses education and states, "As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education" (American Psychological Association, 2003, p. 386). Education is clearly a demonstrated key principle in multicultural training. However, clinicians have had differing reactions in regards to their level of multicultural training and education. European American and African American clinicians have had differing training experiences regarding addressing the topic of race in cross-cultural therapy (Knox et al., 2003). In a study of 12 licensed psychologists (six male, six female) of whom five were African American and five were European American, Knox et al. (2003) found that many of the European American and African American clinicians had had experiences with racially different people prior to graduate school. Those experiences impacted their approach to therapy. The authors found that both groups had largely similar experiences in graduate school in regards to supervision, meeting with clients of different races, and multicultural training activities. However, European American clinicians reported having almost no didactic training in regards to addressing the topic of race (Knox et al., 2003). The authors suggested that this finding was related to the increased discomfort that European American clinicians have reported in regards to addressing race in cross-racial therapy in comparison to that reported by African American clinicians (Knox et al., 2003).

Thompson, Bazile, and Akbar (2004) investigated the perceptions of 201 African Americans (mean age, 35.8 years) on their views regarding psychotherapy and psychoclinicians. The authors inquired as to whether addressing issues of racial differences early in the therapeutic process would be beneficial. They obtained mixed results. Approximately one third of participants felt that a clinician broaching the topic of race was indicative of the clinician's racism or discomfort (Thompson et al., 2004). Another third indicated that they would prefer the clinician to initiate the conversation and would feel relieved (Thompson et al., 2004). The remaining participants were neutral on whether the topic should be broached and were unsure as to whether it would impact therapy (Thompson et al., 2004).

African American psychology students reported having negative experiences in regards to their graduate training regarding race (Knox et al., 2003). Knox et al. (2003) explored African American and European American therapists' experiences regarding race. Their sample consisted of 12 licensed psychologists (six men and six women), of whom five were African American and seven were European American. The African American psychologists discussed feeling as if they were representative of their whole race, had fears of disagreeing with their supervisors, and felt that they needed to change their therapeutic sessions in order to avoid stereotyped perceptions (Knox et al., 2003). These findings were in contrast to zero negative reports made by the European American psychologists. Another important difference in multicultural interaction was found postgraduation (Knox et al., 2003). African American graduates were found to participate in multicultural workshops or conferences, while none of the European

American participants reported taking part in such conferences (Knox et al., 2003). African American graduates reported conducting multicultural training sessions and experiencing cross-racial interactions in their first postgraduate positions, while European American did not (Knox et al., 2003). In regards to addressing race in session, both groups did so when they felt that it was relevant to treatment (Knox et al., 2003). African American clinicians, however, did so more routinely. Both groups felt that positive results can arise from the discussion of race with their clients. The investigation by Knox et al. (2003) brings to light many of the differences that European American and African American clinicians experience in regards to their multicultural training and practices. Although multicultural training of clinicians differ, the impact of a clinician's multicultural orientation on therapeutic alliance can be powerful.

Acknowledging race in cross-cultural therapy has been demonstrated to be a difficult part of the therapeutic process for many clinicians (Maxie et al., 2006). However, the benefits of doing so can improve the therapeutic relationship and provide the client an opportunity to process possible issues related to race and culture. The ability of a clinician to acknowledge race effectively can therefore have lasting implications on treatment.

## Chapter 3: Research Questions/Hypotheses

### Research Question 1

Does a clinician's acknowledgement of visible cultural differences during the hypothetical initial session of treatment affect predicted therapeutic alliance?

### Hypothesis 1

The clinician's acknowledgement of visible cultural differences (race and age) between the clinician and a client as a routine practice during the initial session of treatment was predicted to form therapeutic alliance. This prediction was based on the findings that appropriately addressing culture in treatment could improve the therapeutic relationship and therapeutic alliance (Day-Vines et al., 2007; La Roche & Maxie, 2003; Owen et al., 2011; Vasquez, 2007)

### Research Question 2

Does a clinician's acknowledgement of visible cultural differences during the hypothetical initial session of treatment affect the client's predicted perception of the clinician's cultural competency in working with others of different cultures?

### Hypothesis 2

The clinician's acknowledgement of visible cultural differences (race and age) between the clinician and a client as a routine practice during the initial session of treatment was predictive of a client's perception of the clinician's cross-cultural counseling skills. This prediction was based on the findings that clinician multicultural competency is associated with therapeutic alliance and positive treatment outcomes (Owen et al., 2011).

**Research Question 3**

Does a clinician's acknowledgement of visible cultural differences during the hypothetical initial session affect predicted client attrition?

**Hypothesis 3**

The clinician's acknowledgement of visible cultural differences (race and age) between the clinician and a client as a routine practice during the initial session of treatment was predicted to lower client attrition. This prediction was based on the findings regarding the impact of therapeutic alliance on client attrition (Cournoyer et al., 2007; Sharf et al., 2010).

# Chapter 4: Methodology

## Design and Design Justification

This study used an analog experimental design. It assessed the impact that acknowledging the visible cultural differences of race and age during the initial therapeutic session can have on therapeutic alliance, perception of multicultural competency, and patient dropout through the use of vignettes. The study utilized situational vignettes in order to assess these possible interactions. The use of vignettes had the advantages of being able to collect information simultaneously, manipulate variables in a safe manner, and eliminate variability in intervention execution. The four vignette groups that were used were based on the assumption that there was either a racial difference or an age difference between the client and the clinician. The four groups were (a) broaching race and age, (b) broaching age, (c) broaching race, and (d) not broaching age and race. A between-groups factor was necessary for this study to discern the differences between the treatment groups and a control group (not broaching age and race). This design had the advantage of allowing for various levels of a variable to be tested simultaneously between groups. The assignment of clients to the experimental and control group was conducted randomly. Random assignment was performed in order to increase internal validity.

## Participants

The subject population was recruited in an outpatient setting. The subject participants of this study were clients who were participating in treatment at the Philadelphia College of Osteopathic Medicine's (PCOM) Center for Brief Therapy. The study consisted of 26 participants (10 male; 16 female), ranging in age from 23 to 77

years ($M$ = 34.96; $SD$ = 11.85). The ethnic background of the participants was 84.6% European American and 15.4% African American. The Center for Brief Therapy is a comprehensive outpatient clinic in the Philadelphia, PA, area. The Center for Brief Therapy provides CBT focused clinical assessment, treatment, and consultation services to adults, adolescents, and children. The staff consists of advanced graduate students in clinical psychology, psychology interns, and postdoctoral fellows. The subject population were adults 18 years and older and seeking psychological treatment. The study utilized the assistance of two graduate assistants at the Center for Brief Therapy in order to assist with collecting data when the student investigator was not present. The graduate assistants were doctoral-level psychology students at PCOM and acted in the role of co-investigators.

**Inclusion/Exclusion Criteria**

Specific criteria were utilized in the selection of the participants for this study. In terms of the inclusion criteria for the client subject group, the participants were required to (a) be a new or current client at the PCOM Center for Brief Therapy, (b) be age 18 years or older, and (c) be able to read English at an eighth-grade or higher level. The inclusion criterion for the co-investigators (when the student investigator was not present) was being a graduate assistant at the PCOM Center for Brief Therapy.

Specific exclusion criteria were utilized in order to increase the validity of the study. The exclusion criteria for the client subject population consisted of (a) Those under the age of 18 years, and (b) participants who could not read English at an eight-

grade or higher level. The exclusion criterion for the co-investigator was not currently being a graduate assistant at the PCOM Center for Brief Therapy.

**Recruitment**

Recruitment for the client subject population was conducted by the student investigator, Jean-Pierre Assouad, and the PCOM Center for Brief Therapy graduate assistants (GAs), who served as co-investigators. During the time when new or current adult clients were in the waiting room, the student investigator or a GA (depending on student investigator availability) presented the clients with an advertisement of the study prior to their appointment with their therapist. The clients were instructed to notify the student investigator or GA if they wished to take part in the study. If clients expressed an interest in taking part in the study, the student investigator or GA met with them in the front office or student investigator's office to obtain informed consent. The student investigator or GA answered questions that the clients might have had about the study. The clients also had the opportunity to complete the study materials prior to their session or following the session. Clients were offered an incentive to receive a $5 Target gift card, which was provided once the clients completed the appropriate measures.

Recruitment of the GA population took place by the student investigator at the Center for Brief Therapy. The student investigator met and presented the study to the GAs at the Center for Brief Therapy. The student investigator obtained the Collaborative Institutional Training Initiative (CITI) certification of the GAs prior to their enrollment as co-investigators in the study. The GAs for the study were Kristine Spano, M. Ed. and Elizabet Santana, M.A.

## Vignettes

The study utilized four vignettes that served the purpose of representing a hypothetical situation in which a client is interacting with a therapist of a different culture. The vignettes were developed from the perspective of a first-session meeting in order to evaluate the efficacy of discussing cultural difference at the first possible face-to-face interaction between a therapist and a client. The vignettes being based on a hypothetical first session also had the added benefit of accounting for the undesirable likelihood of dependent variables being affected by factors other than the broaching intervention. This design would help isolate the broaching intervention as the factor that impacted therapeutic alliance, perceived counselor cultural competency, and attrition. The vignettes addressed four situations in which (a) the therapist was the same age/different race than the client and the difference of race is broached; (b) the therapist was the same race/different age and the difference of age is broached; (c) the therapist was a different race/age from the client, in which both differences in age and race are broached; and (d) the therapist and client were a different race/age and there was no broaching behavior. In the broaching vignettes, the therapist performed the intervention at the end of the intake. The four situations were developed using a variable matrix that accounted for the different interactions that the independent variables could have with the dependent.

## Measures

### Working Alliance Inventory-Client Version

The Working Alliance Inventory (WAI) is a measure developed by Adam Horvath to measure the working alliance, or strength of therapeutic bond, between a clinician and a client. The three subscales of the WAI are Goals, Tasks, and Bond (Horvath & Greenberg, 1989). These subtests were chosen based on Bordin's (1976) belief that they are the key components in the quality and development of the therapeutic alliance. Goals are understood as the mutually agreed upon objectives of the intervention. Tasks are defined as cognitions and behaviors that take place during the session, which should be perceived as relevant and useful by both the clinician and the client. Bonds can be understood as the positive attachments that the client and clinician form towards each other in treatment, which can include such factors as mutual trust, acceptance, and confidence. The WAI is structured as a 36-item measurement that asks the test taker to rate the degree to which the person agrees with a statement on a 7-point Likert scale ranging from 1 (*never*) to 7 (*always*). A short version of the WAI, which consists of 12 total items, and a therapist version, which consists of 12 items are also available. The equally distributed statements focus on the subtest scales and are completed by the clinician and the client. The WAI was developed across three clinical studies, which included a total 60 adult counselor-client dyads between the ages of 17 to 65 years. The majority of the clients were women and had at least a high-school education. Also, a minimum of 31 subjects were from an urban population. WAI has also been found to be both valid and reliable through the research of Horvath and

Greenberg (1989). The WAI was found to have adequate internal consistence, in which the client version had an alpha of .93, while the clinician version had an alpha of .87 (Horvath & Greenberg, 1989). The WAI was also found to have adequate convergence validity, with support for the discriminant validity of the Goals scale. Horvath and Greenberg (1989) conducted ratings by experts, professionals, and clinical trials and found the WAI to be an efficacious predictor of counseling success.

**Cross Cultural Counseling Inventory-Revised**

The Cross Cultural Counseling Inventory-Revised (CCCI-R) is a measure developed by LaFromboise, Coleman and Hernandez (1991). The purpose of the CCCI-R is to evaluate cross-cultural counseling competencies (LaFromboise et al., 1991). The three subscales of the CCCI-R are Cross Cultural Counseling Skill, Sociopolitical Awareness, and Cultural Sensitivity. LaFromboise et al. (1991) described cross-cultural counseling competency as the counselor's self-awareness, use of appropriate counseling skills in communication with the client, and understanding of his or her role. Sociopolitical awareness is described as the counselor's awareness of his or her strengths and weaknesses and how that awareness may impact the counseling process. Cultural sensitivity is described as the counselor's ability to empathize with the client and understand the interpersonal and environmental demands that the client is experiencing. The CCCI-R is structured as a 20-item scale in which the client is asked to rate the competency of the counselor on a 6-point Likert scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). The content validity of the CCCI-R was normed across eight graduate students from educational and counseling psychology Ph.D. programs. The

inter-rater reliability of the CCCI-R was normed across three expert raters through the review of cross-cultural counseling vignettes. The raters consisted of one African American man, one European-American man, and one Native American woman. The raters reviewed 13 videotapes between practicum students and confederate clients, in which they rated the counselor. The CCCI-R was found to have adequate content validity as measured by LaFromboise et al. (1991) and yielded high item-objective congruence. A factorial analysis of the CCCI-R was also completed, which revealed a 3-factor orthogonal solution with the factors of cross-cultural counseling skill, sociopolitical awareness, and cultural sensitivity (LaFromboise et al., 1991). The factor analysis was conducted across 86 university student raters, who were of diverse age, ethnicity, SES, and level of training within their university program (LaFromboise et al., 1991). For the purposes of this study, only questions related to cross-cultural counseling skill were assessed. Focusing on cross-cultural counseling skills questions was done because of the applicability of those questions to the design of the study and the subject's ability to answer such questions based on the vignette presented. The questions that are part of the cross-cultural counseling skill subset are 1, 2, 4, 8, 11, 12, 13, 16, 19, and 20. LaFromboise et al. (1991) do suggest a need to further validate the CCCI-R through larger and more diverse subject populations.

**Client Attrition Questionnaire**

The Client Attrition Questionnaire (CAQ) measured the clients' likelihood for dropout through the use of three multiple-choice questions that were assessed on a 7-point Likert scale. The scale asked the clients to rate the likelihood that he or she would

agree to meet with the therapist again (See Appendix A). Given the vignette, the questions investigate the likelihood that a client would return after the first session of treatment, return after the third session, and complete the course of therapy.

## Procedures

The student investigator presented the study to the GAs and obtained their CITI training certificates and curriculum vitae. The student investigator provided to the GAs a form that outlined the procedures for data collection (See Appendix B) and an advertisement that was presented to potential subjects. The advertisement was posted in the waiting area of the Center for Brief Therapy. The student investigator also provide the GAs with a vignette distribution form that contained the vignette type (A, B, C, or D) that the subject was assigned (See Appendix C). The four groups were (a) broaching race and age, (b) broaching age, (c) broaching race, and (d) not broaching age and race. The form contained a random distribution pattern and was kept in the front office for the student investigator and GAs to access and track the distribution of vignettes. The student investigator provided the GAs with a packet that contained the "subject" informed-consent forms and the study materials for the participants to review and complete. This packet was kept at the front office and was labeled S1-S36. The student investigator also provided the GAs with a packet to provide to the subjects. Each packet contained a description of the study (See Appendix D), one of the four situational vignettes (See Appendix E), a copy of the Working Alliance Inventory-Client Version, the cultural counseling skills subscale of the Cross Cultural Counseling Inventory-Revised, and a questionnaire measuring client dropout potential (See Appendix A).

In the event that a new or current client entered the Center for Brief Therapy, the student investigator or GA attempted to recruit the client. The student investigator or GA presented to the potential subject the advertisement of the study. An advertisement of the study was also posted in the waiting room. The clients were asked to notify the GA or student investigator if they would like to take part in the study. If clients expressed interest to the student investigator or GA in taking part in the study, the student investigator or GA met privately with the clients to obtain informed consent. The meetings took place in the front office or in the student investigator's office. The clients were also provided the opportunity to review the informed consent form in the waiting room or to take it home to review. Clients were eligible to take part in the study only once.

After the student investigator or GA obtained written informed consent, the student investigator or GA provided clients with a packet that contained the study materials. Each packet was randomly assigned and based on the vignette distribution form (See Appendix C). The student investigator or GA crossed out each client's position on the vignette distribution form, which was kept in the front office. Clients were allowed to complete the packet prior to their therapy session or following the session. Once clients completed the packet, the student investigator or GA provided the client with a $5 Target gift card. The gift cards were kept in an envelope in the front office. Once the student investigator or GA received the completed packet, he or she placed it in the student investigators' mailbox, which is in a locked closet at the Center

for Brief Therapy. The student investigator collected the completed packets at the end of each week for data analysis.

Following data collection, the student investigator retroactively collected client demographic information. The information collected was age, ethnicity, and gender. This information was collected by identifying the name of the client from his or her signature on the informed consent form, and looking up the information in his or her chart. The demographic information was recorded on a Demographic Data Form.

## Chapter 5: Results

This study sought to measure the impact of acknowledging cultural difference on three dependent variables. The dependent variables in this study were (a) therapeutic alliance, as measured by the Working Alliance Inventory (WAI)-Client Version; (b) clinician cross-cultural counseling skill, as measured by the Cross Cultural Counseling Skill subscale of the Cross Cultural Competency Inventory-Revised (CCCI-R); and (c) attrition, as measured by the Client Attrition Questionnaire (CAQ). The independent variable in this study was the performance of the intervention. The independent variable was measured across four groups: an intervention group involving race, an intervention group involving age, an intervention group involving race and age, and a control group in which broaching did not take place when there were age and racial differences.

A multivariate analysis of variance (MANOVA) and a univariate analysis of variance (ANOVA) were utilized in this analysis because of their ability to test the differences in means for the independent variable on a combination of dependent variables. A MANOVA allows one to measure multiple dependent variables, test the effects of the independent variables simultaneously, increase the chance of finding the effect that the independent variable has, and help control for Type 1 errors. ANOVAs were utilized to compare means with groups that had only one dependent variable. The analysis was based on a cross-sectional design in order to collect data and measure the impact of the independent variable at the same time. The benefit of the cross-sectional design was that data could be collected quickly and had a low expense. Therefore, the utilization of this statistical analysis model was applied to determine whether a

relationship existed between the acknowledging cultural differences and the independent variables.

The MANOVA and ANOVA tested the validity of the three hypotheses of this study. The first hypothesis was analyzed to measure whether there was a difference in therapeutic alliance between the control group and the experimental group as indicated by the WAI results. The second hypothesis was analyzed to measure whether there was a difference in clinician multicultural competency between the control group and the experimental group as indicated by the results of the Cross Cultural Counseling Skills subscale of the CCCI-R. The third hypothesis was analyzed to measure whether there was a difference in attrition rates between the control group and the experimental group as indicated by the attrition criteria (attending the third session of treatment).

A power analysis was completed in order to determine the number of participants who were required in this study (Cohen, 1988). A MANOVA examined the hypotheses of the study. The $\alpha$ for the MANOVA was set at .05. To achieve a power of .95 and a medium effect size a sample size of 36 was required to detect the critical $F$ value ($F$ = 2.08); however, because of low participant recruitment, the total sample size of the study was 26.

**Statistical Analysis**

A comprehensive analysis was conducted to determine the relationship between the dependent variables of the WAI-Total, the CCCI-R-Total, and the CAQ-Total. The relationship of the subgroups of the WAI was also compared to the other dependent variables and consisted of WAI-Task, the WAI-Bond, and the WAI-Goal.

An analysis of whether a correlation existed between the dependent variables was conducted using Pearson's product-moment correlation coefficient. As outlined in Table 1, a positive correlation existed between the WAI-Total and its respective subgroups (WAI-Total/WAI-Task: $r = .900$, $p = .000$; WAI-Total/WAI-Bond: $r = .839$, $p = .000$; WAI-Total/WAI-Goal: $r = .895$, $p = .000$). In comparing the CAQ-Total with the WAI-Total and the WAI subgroups, the WAI-Total score had a significant negative correlation with the CAQ-Total score ($r = -.558$, $p = .003$), and a significant negative correlation with the WAI-Task ($r = -.572$, $p = .002$) and the WAI-Goal ($r = -.522$, $p = .006$). No significant correlation was found between the CAQ-Total and the WAI-Bond ($r = -.364$, $p = .067$) and the CCCI-R-Total ($r = -.140$, $p = .494$). In evaluating the relationship that the CCCI-R-Total shared with the other dependent variables, the only significant correlation found was with the WAI-Bond ($r = .435$, $p = .026$). Note that the CCCI-R-Total approached significance when compared to the WAI-Total, ($r = .384$, $p = .053$). See Table 1 and Table 2 for means, standard deviations, and correlations.

Table 1

*Correlations Between Hypothetical Working Alliance, Perceived Clinician Cultural Competency, and Hypothetical Attrition*

| Measure | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| 1. WAI-To | *.900*** | *.839*** | *.895*** | *.384* | *-.558*** |
| 2. WAI-T | | *.610*** | *.734*** | *.267* | *-.572*** |
| 3. WAI-B | | | *.625*** | *.435** | *-.364* |
| 4. WAI-G | | | | *.322* | *-.522*** |
| 5. CCCI-R-T | | | | | *-.140* |
| 6. CAQ-T | | | | | |

*Note.* WAI-To = Working Alliance Inventory (Total); WAI-T = Working Alliance Inventory (Task); WAI-B = Working Alliance Inventory (Bond); WAI-G = Working Alliance Inventory (Goal); CCCI-R-T = Cross Cultural Counseling Inventory-Revised (Total); CAQ-T = Client Attrition Questionnaire (Total)

*$p < .05$. **$p < .01$.

Table 2

*Means and Standard Deviations for Hypothetical Working Alliance, Perceived Clinician Cultural Competency and Hypothetical Attrition*

| Measure | *M* | *SD* |
|---|---|---|
| Working Alliance Inventory (Total) | 215.27 | 19.93 |
| Working Alliance Inventory-Task | 72.73 | 8.15 |
| Working Alliance Inventory-Bond | 71.62 | 7.13 |
| Working Alliance Inventory-Goal | 70.92 | 7.39 |
| Cross Cultural Counseling Inventory-Revised | 54.69 | 5.57 |
| Client Attrition Questionnaire (Total) | 5.50 | 3.79 |

The first hypothesis was analyzed utilizing a univariate ANOVA, with vignette type as the independent variable and the WAI-Total as the dependent variable. The Levene's test for equality of variances was not found to be significant, $F(3, 22) = .35$, $p = .793$. This finding indicates that the variances across the groups were not significantly different. A univariate ANOVA revealed that there were no significant differences across vignette conditions on the WAI-Total, $F(3, 353.87) = .88$, $p = .468$, and therefore no further posthoc testing was warranted. See Table 3 for the means and standard deviations for the each vignette group based on the WAI-Total.

Table 3

*Means and Standard Deviations for Vignette Type with WAI-Total as the Dependent Variable*

| Condition | *M* | *SD* |
|---|---|---|
| Vignette A | 220.50 | 14.77 |
| Vignette B | 205.75 | 22.52 |
| Vignette C | 218.20 | 22.59 |
| Vignette D | 219.57 | 19.10 |

The first hypothesis was also analyzed utilizing a MANOVA with vignette type as the independent variable and the WAI-Task, WAI-Bond, and WAI-Goal as the dependent variables. See Table 4 for the means and standard deviations for the each vignette group based on the WAI subgroups.

Table 4

*Means and Standard Deviations for Vignette Type with WAI-Task, WAI-Bond, and WAI-Goal as the Dependent Variables*

| | WAI-Task | | WAI-Bond | | WAI-Goal | |
|---|---|---|---|---|---|---|
| Condition | *M* | *SD* | *M* | *SD* | *M* | *SD* |
| Vignette A | 77.33 | 5.32 | 71.67 | 5.92 | 71.50 | 4.76 |
| Vignette B | 68.38 | 7.89 | 70.00 | 6.95 | 67.38 | 9.72 |
| Vignette C | 70.60 | 9.29 | 74.80 | 10.03 | 72.80 | 5.36 |
| Vignette D | 75.29 | 8.08 | 71.14 | 6.87 | 73.14 | 7.31 |

These three variables were significantly intercorrelated, thereby justifying their use as dependent variables in this analysis. Based on Box's test of equality of covariance matrices, Box's $M = 32.941$, $F(18, 1244.18) = 1.33$, $p = .16$, the observed covariances of the independent variables were equal across groups. The overall test for the MANOVA revealed a significant difference on the dependent variables by type of vignette, Roy's largest root = .583, $F(3, 22) = 4.273$, $p = .016$. The Levene's test for equality of variances across variables was not found to be significant, indicating that the error variances across independent variables were equal across groups, specifically for Levene's test for equality of variances, on WAI-Task, $F(3, 22) = .66$, $p = .588$; WAI-Bond, $F(3, 22) = .650$, $p = .591$; and WAI-Goal, $F(3, 22) = 1.54$, $p = .23$.

Posthoc tests between subjects effects employing univariate ANOVAs revealed WAI-Task, $F(3, 115.76) = 1.94$, $p = .153$; WAI-Bond, $F(3, 24.39) = .45$, $p = .72$; WAI-

Goal, $F(3, 51.61) = .94$, $p = .44$. Of particular note, the power for each of these tests was low, WAI-Total = .21,WAI-Task = .43, WAI-Bond = .13, WAI-Goal = .22, respectively. Since the posthoc univariate *F* tests were not significant, further tests, such as Tukey, were not justified and therefore not required.

The second hypothesis was analyzed with a one-way ANOVA using type of vignette as the independent variable and the CCCI-R-Total score as the dependent variable. See Table 5 for the means and standard deviations for the each vignette group.

Table 5

*Means and Standard Deviations for Vignette Type with CCCIR-Total as the Dependent Variable*

| Condition | *M* | *SD* |
|---|---|---|
| Vignette A | 54.00 | 4.60 |
| Vignette B | 51.25 | 2.59 |
| Vignette C | 59.4 | .89 |
| Vignette D | 55.86 | 3.48 |

The Levene's test for equality of variances was significant, Levene statistic (3, 22) = 5.18, $p = .007$, indicating that the variances across the groups were significantly different. A univariate ANOVA revealed a difference between groups that approached significance, between groups effect $F(3, 22) = 2.87$, $p = .06$. Given that this finding was very close to

the .05 level and in view of the significant level test, a Games-Howell posthoc procedure was conducted. These findings revealed that there was a difference that approached significance ($p$ = .06) between the Vignette Group B (broaching age) and Vignette Group C (broaching race and age).

The third hypothesis was analyzed with a one-way ANOVA using type of vignette as the independent variable and CAQ-Total as the dependent variable. See Table 6 for the means and standard deviations for the each vignette group.

Table 6

*Means and Standard Deviations for Vignette Type with CAQ-Total as the Dependent Variable*

| Condition | *M* | *SD* |
|---|---|---|
| Vignette A | 4.33 | 1.51 |
| Vignette B | 7.38 | 4.78 |
| Vignette C | 6.80 | 5.22 |
| Vignette D | 3.43 | .79 |

The Levene's test for equality of variances across groups was significant, Levene statistic (3, 22) = 8.09, $p$ = .001; however, the overall univariate $F$ tests between conditions were not significant, between groups effect $F(3, 22) = 1.93$, $p$ = .15, and therefore no posthoc testing was conducted.

**Additional Findings**

To mine the data, the vignette variable was recoded to create two groups: a group in which diversity was broached compared against a group in which it was not broached. The Levene's test for equality of variances for each of the variables revealed that variances were significantly different on the CAQ-Total, but not on other totals (WAI-Total, $F = .954$, $p = .35$; CCCI-R-Total, $F = 1.493$, $p = .25$; CAQ-Total, $F = 8.89$, $p = .011$). Three *t* tests were conducted to compare the two groups on the dependent variables; none reached significance.

A one-way ANOVA was conducted using a group consisting of broaching one area of visible cultural difference (Vignettes A and B) in comparison to a group that broached two visible differences (Vignette C) and a group in which no broaching took place (Vignette D). The Levene's test for equality of variances on these variables revealed that the variances were significant only across the CAQ-Total, and not on the other variables. Univariate *F* tests revealed no significant differences between these groups on the CAQ-Total, $F(2, 23) = 1.57$, $p = .23$, and the WAI-Total, $F(2, 23) = .378$, $p = .69$; however, on the CCCIR-Total there was a significant difference between groups, $F(2, 23) = 3.79$, $p = .038$. Posthoc analyses were conducted to determine where the differences between groups existed on the CCCI-R. The results of a Games-Howell posthoc analysis revealed a significant difference between Groups 1 and 2 ($p = .003$) on the CCCI-R. The difference between Groups 2 and 3, however, approached significance ($p = .08$). The means for the groups were Group 1 = 52.43 and Group 2 = 59.4. This finding indicates that there was a significantly lower score for Group 1 on the CCCI-R

than for Group 2, which indicated a highly perceived cultural competency in the vignette consisting of broaching two cultural differences rather than one.

Using the same group structure, a MANOVA was conducted with WAI-Task, WAI-Bond, and WAI-Goal as the dependent variables. The Box's test of the equality of covariance matrices was not significant, Box's $M = 21.91$, $F(12, 731.31) = 1.35$, $p = .185$, indicating that the covariance matrices of the dependent variables were equal across groups. The overall MANOVA was not significant between the groups; therefore, no further testing was warranted.

An additional MANOVA was conducted in which the independent variable was the combination of Vignette Groups A, B, and C as one group and Vignette Group D as a second group. The WAI-Task, WAI-Bond, and WAI-Goal were the dependent variables. The Box's test of equality of covariance matrices was not significant, Box's $M = 10.16$, $F(6, 777.70) = 1.35$, $p = .233$. The overall test of significance for the MANOVA was not significant and no further testing was warranted.

An analysis to examine whether a correlation exists between the dependent variables and the subjects' visible cultural demographics (age, race, and gender) was conducted using Pearson's product-moment correlation coefficient. In regards to age, a significant negative correlation was found with the WAI-Total ($r = -.512$, $p = .007$), the WAI-Bond ($r = -.393$, $p = .047$), and the WAI-Goal ($r = -.660$, $p = .000$). In regards to gender, a significant difference was found on the CAQ-Total score, $t(24) = -1.90$, $p = .001$, between male subjects ($M = 3.80$, $SD = .79$) and female subjects ($M = 6.56$, $SD =$

4.52). No significant differences were detected between the dependent variables based on race.

## Chapter 6: Discussion

The impact that therapeutic alliance and cultural factors have on treatment outcomes has been well documented (Martin et al., 2000; Vasquez, 2007). The purpose of this study was to investigate the impact that broaching visible cultural differences in a hypothetical intake session would have on therapeutic alliance, clients' perception of clinician cross cultural competency, and potential client attrition. The study utilized a vignette format and involved subjects who were clients at the PCOM Center for Brief Therapy. The Working Alliance Inventory (WAI)-Client Version, select parts of the Cross Cultural Counseling Inventory-Revised (CCCI-R), and a Client Attrition Questionnaire (CAQ) were utilized in order to test the impact that broaching visible cultural difference would have on the dependent variables.

The impact that the intervention had on the therapeutic alliance, perceived counselor cultural competency, and potential attrition were assessed individually. In examining the subgroups of the WAI, the groups were found to be significantly intercorrelated, which justified the use of the WAI as a dependent measure of therapeutic alliance. In analyzing whether the subgroups of the WAI differed across the vignette types, findings revealed that there was a significant difference between the groups, meaning that therapeutic alliance demonstrated to be different depending on the situation in which the intervention was presented and in comparison to the control group. However, upon further investigation, specific differences between groups could not be identified. This finding may be the result of such factors as the lack of sufficient participants in the study. Another possible reason for the lack of significance between groups may be the possible homogeneity of the vignettes. The vignettes may not have

been perceived by the subjects to be different enough to adequately test for the intervention. Another explanation for the findings may be that therapeutic alliance, regardless of the therapist interventions, needs time beyond the initial session of treatment to be sufficiently developed to impact the WAI scores. Prior research has demonstrated that therapeutic alliance typically peaks during the third session (Saltzman et al., 1976). As the intervention took place in the hypothetical first session of treatment, the time may not have been sufficient for the client to develop a significant enough difference in therapeutic alliance when compared to a group in which the intervention did not take place. One should also consider that broaching cultural difference during the first session might not be a significant enough intervention to impact therapeutic alliance. Tsang, Bogo, and Lee (2011) investigated the therapist characteristics that may affect therapeutic alliance in the first session of treatment. Their study involved nine cases from a range of mental-health service programs, in which the clients and clinicians were of different diverse backgrounds. In analyzing their findings, the authors discovered two patterns that led to positive cross-cultural encounters. These included the following: "(a) the practitioner's recognition of the client's major needs and concerns, and the communication of a cognitive understanding of them, leading to the negotiation of agreed-upon purpose; and (b) the practitioner's emotional engagement with the client" (Tsang et al., 2011, p. 83). Although this study made an acknowledgement of cultural differences and allowed for the client to voice concerns, it did not demonstrate culturally sensitive therapist behaviors beyond this action. The lack of dialogue concerning the client's needs and concerns related to culture, along with the void of emotional engagement with a client, may account for the lack of differences in therapeutic alliance values between the groups.

In examining the impact of the intervention on the client's perceived cultural competency of the clinician, a close to significant difference was found between the vignette groups. In analyzing the specific differences of CCCI-R results across the vignettes, a significant difference was found between situations in which a clinician broached only age difference and a situation in which a clinician broached both age and race differences. This result indicated that a clinician who broaches multiple cultural differences would be perceived to have a higher cultural competency than a clinician who broached only one visible difference. Although the situation in Vignette B identified only one visible difference, acknowledging various aspects of a client's cultural identity might increase the clinician's cultural competency. Therefore, a clinician's attempt to identify multiple visible cultural differences may have favorable results when broaching cultural differences during the intake. The implementation of the intervention alone did not show to impact CCCI-R scores in comparison to a control group. An explanation for these findings can again be related to the lack of power in the study and the possibility that the vignettes did not adequately assess for the intervention. One should also consider that the CCCI-R may not be an adequate measure of counselor cultural competency. Ridley and Shaw-Ridley (2011) discussed the limitations of the CCCI-R, which include the assumption that clients have the appropriate skills and knowledge to rate clinician cultural competency.

Broaching visible cultural differences may not have a significant impact on a client's perception of clinician cultural competency. Broaching visible cultural differences may be one of many culturally sensitive activities that clinicians can take part in to develop a client's perception of their multicultural competency. Owen et al. (2011) made the point that a therapist's multicultural competency may have more to do with the

therapeutic relationship rather than a generalized therapist characteristic and that clients may not be attuned to when cultural approaches are taking place in treatment. The participants in this study, therefore, may have not have developed an adequate enough impression of the therapeutic relationship or the hypothetical therapist's cultural approach in order to identify the broaching to be a significant indication of the clinician's multicultural competence.

In examining the impact of the intervention on potential client attrition, there was a statistically significant difference between the groups as a whole. However, upon further investigation, there were no significant differences between the individual groups. This finding may be caused by the potential reasons previously listed, such as a sample size not large enough to detect the difference or the vignettes being too similar to each other. Although prior research demonstrated that therapeutic alliance is a factor in decreasing attrition (Barrett et al., 2008), the findings of the current study indicated that there was not a significant difference in therapeutic alliance between groups. The current study hypothesized that attrition would decrease as a result of an increase in therapeutic alliance. Owing to a lack of differences among the vignette groups concerning therapeutic alliance, it's worth considering that therapeutic alliance did not develop strongly enough in the hypothetical intake sessions to impact attrition.

The age and gender of the subjects did demonstrate to be factors that impacted aspects of the results. There was a significant negative correlation between a client's age and the WAI as a whole. As age increased, working alliance decreased, and vice versa. This finding implies that age is a factor that should be considered in the evaluation of therapeutic alliance and that therapeutic alliance may be more difficult to develop with older clients. A clinician may benefit from this knowledge by utilizing additional

therapeutic-alliance building techniques with older clients. Clinicians may also want to "check in" on the therapeutic alliance between themselves and their clients on a more regular basis in order to adequately assess the status of their relationship. There was also a significant difference in potential attrition scores between male and female participants. Results indicated that female clients were significantly more likely than male clients to make a higher rating of their potential to prematurely drop out of treatment. This finding is supported by research in the substance abuse field demonstrating that women in outpatient substance abuse treatment are more likely than male clients to drop out of treatment (King & Canada, 2004). Owing to the correlation between therapeutic alliance and attrition (Sharf et al., 2010), clinicians may want to "check in" on the therapeutic alliance between themselves and their female clients regularly in order to help more thoroughly assess attrition potential.

**Limitations**

Certain limitations present in this study restricted the generalizability of the findings. One limitation is that the study was limited to participants in the Philadelphia area, which is urban. Although clients from suburban or rural areas may travel into Philadelphia for treatment, the results may not be fully representative of such a population. The study also did not specify the racial difference (i.e. African American, Asian, Hispanic, etc.) between the client and therapist and only specified a "significant" age difference rather than a specific difference in age. The results may have varied based on age or racial differences. Another limitation of the study was its focus on the visible

cultural differences of race and age. Other visible and invisible cultural differences were not examined, such as gender, religion, region, and SES.

Another significant limitation of this study was the use of a vignette study design. A client's response to a vignette may not accurately represent his or her response in a real-world interaction, which is a threat to external validity. Barter and Renold (2000) examined the application of this methodology in conducting social research with children and young people. In discussing the theoretical and methodological limitations of this strategy, the authors focused on many important aspects. One limitation discussed was the discrepancy that can take place between the vignette and social reality. The authors pointed out that the way people believe they may act in a vignette situation may not be analogous with reality. Another limitation of using a vignette research design is the lack of interaction between an individual and the environment, which can be a confounding variable, especially in socially based research (Barter & Renold, 2000). Barter and Renold (2000) also discussed the possibility that participants' attempts to appear socially desirable in their responses may not be reflective of their true actions or beliefs.

Collett and Childs (2011) further examined the limitations of vignettes through the utilization of affect control theory to investigate the differences between vignettes and more experimental methods of research. The authors distributed short scenarios describing a situation along with a questionnaire to 328 students in sociology and business classes. They also created a laboratory experiment with 116 undergraduate students that simulated the process described in the vignettes. In comparing the findings from the two methodologies, the authors discovered a significant difference between the

vignette and the laboratory experiment design. They stated that there may be a difference in results when a subject is actually able to experience, rather than imagine, a process. The authors stated that this difference may result from the ability to experience emotions in the laboratory process, which may be difficult to generate in vignettes. The authors discussed how participants reading vignettes may have difficulty experiencing fundamental sentiments, be less likely to imagine themselves in the situation, or be unable to realize the personal significance of the situation. The pitfalls of a vignette design were also discussed by Hughes and Huby (2002) in reflecting on its application in social and nursing research. The authors echoed the findings of Barter and Renold (2000) regarding the possibility that the experiences of vignette characters may not represent real-life experiences. The authors also discussed how a vignette design can be problematic for participants with learning disabilities, who may have difficulty with multiple words and sentences. Although vignettes have marked advantages, such as the ability to generate data quickly with relatively low cost (Hughes & Huby, 2002), the limitations and validity concerns must be considered in the interpretation and application of research data.

Client variables that impact the therapeutic alliance may go beyond the intervention and could not be controlled in this study. Such variables may consist of, but are not limited to, cultural experiences outside of therapy, the client's view of the clinician and previous experience with clinicians, external information that the client experiences, and global events. The study also did not take into account the cultural

identity development of the client, which may impact how he or she interpreted the vignette.

The subject demographics of the study are also a limiting factor. The average age of participants was 34.96 years, with 80% of the subject pool being 43 years old and younger. The study, therefore, is not reflective of older clients' perceptions. Another limiting demographic factor is the race of the subjects. The majority of the subjects in the study were European American, which decreases the generalizability of the study towards other races. Gender is also a limiting factor in this study because of 61.5% of the participants were female. Additional information from a male perspective may impact outcome.

Another limitation is that the clients who agreed to participate in the study might have responded differently in comparison to the average client in cross-cultural therapy. This possible difference could have led to the selection of clients who were highly receptive to the acknowledgement of culture by the clinician. This study also did not investigate the most appropriate ways to handle situations in which a client expresses concerns regarding visible cultural differences. The handling of these concerns may impact the therapeutic alliance, the perception of the clinician's multicultural competency, and attrition. The study also did not examine the impact of acknowledging visible cultural differences in later sessions of treatment, which may also impact the reaction of the client to the intervention.

An important limitation of the study was the inability to determine why certain clients stay or drop out of treatment. The study was measuring potential attrition on the

basis that the clients attended the first session; however, clients drop out of treatment at different points throughout the therapeutic process. Clients may also decide to remain in treatment for factors beyond that of the acknowledgement of culture. Investigating the reasons clients stay or drop out of treatment was beyond the scope of the study, which was to determine whether a correlation existed between potential treatment attrition and the acknowledgement of visible cultural differences.

One should also note that the results should be interpreted carefully because the study was underpowered. The inability to obtain the required sample size to meet power carries the implications that the results may not be fully representative of the population of interest.

**Implications**

Certain implications are present based on the findings of the study. One implication is that the acknowledgement of multiple cultural differences in the first session of treatment has a positive impact on the client's perceived cross-cultural competency of the clinician. This finding would provide the clinician an empirical foundation for bringing up different visible cultural differences in cross-cultural therapy. The increase in the perception of cultural competency may increase the clinician's credibility with clients and improve the client's psychological well-being.

This study has relevance to the practice of psychology through its implications for cross-cultural therapy. Cross-cultural interaction is a factor of clinical practice that is frequently experienced by physicians. This study proposed a way for clinicians to better interact with a client of a different culture and proposed a method that may lead to

improved treatment outcomes in terms of retention in treatment. Clients of differing cultural backgrounds may have an opportunity to have their experiences acknowledged by the clinician. The study addressed the issues of attrition, therapeutic alliance, and cross-cultural competency. The findings of this study contribute to the research on the efficacy of discussing culture in a therapeutic setting.

**Future Directions**

These findings may have implications for the most effective approach toward treatment of clients from different cultures. Building upon the body of research regarding cross-cultural therapy in order to most effectively serve this population is important. Future research should expand on the current factors that were hypothesized to improve cross-cultural therapy in the hopes of more effectively impacting therapeutic alliance and attrition. Future research should further investigate the study of therapeutic alliance and the impact of culture on the development of therapeutic alliance. Future work should focus on how to approach culture more effectively in therapy and on its true value to the therapeutic alliance.

Based on the findings of this study, additional research is recommended. Future research should evolve from the vignette study design into an experimental in-session intervention. This design would decrease the external-validity threats present in a vignette study design and provide additional information on the efficacy of the intervention. Future research can help control for the limitations of a vignette study design, while also maintaining some of its advantages. Rather than using a written story in describing a situation, utilizing video clips of actors portraying the situations in the

vignette may be beneficial. Doing so may allow for subjects to develop a visual representation of the situation and perhaps connect with the situation on a more personal level. Also of benefit would be an investigation of the impact of culturally contextual discussions following the broaching behavior on the dependent variables, as would an investigation of the impact of broaching visible and invisible differences across different sessions in treatment. Also recommended is research that focuses on the impact of acknowledging culture in the initial session across a larger and more diverse population. This research would provide an indication of the efficacy of this intervention across populations, rather than being limited to the present population. Future research also should expand beyond an outpatient setting and focus on various settings for psychological treatment. A greater understanding of the impact of this intervention across settings would further define its utility. In addition, future research should take into account the invisible cultural characteristics that make up an individual (e.g., religion and SES). Noting the effect of the intervention when acknowledging invisible cultural characteristics would be important. A clinician can learn about a client's invisible cultural differences through verbal inquiry.

Based on the findings, investigating the impact of broaching multiple areas of cultural difference on the therapeutic relationship is also recommended. Incorporating additional measures to assess for therapeutic alliance, cross-cultural competency, and attrition would be beneficial, as would future research to measure attrition beyond the intake session. Such research would provide greater information on the impact of the intervention on attrition. Further, obtaining qualitative information from the patient

rather than focusing on specific measures would be beneficial. Note that the current study was not developed to demonstrate how to appropriately handle situations in which the client expresses concerns regarding visible racial differences. Future research should focus on appropriate ways for a clinician to address such situations when they arise in the first session of treatment. Future research should also explore the opportunities to utilize the broaching and discussion of cultural differences in the training of future clinicians. These situations may be reproducible through the use of role plays and mock patient interviews. Clinicians may then have the opportunity to practice and receive feedback on their sensitivity to cultural differences and their abilities to effectively discuss diversity concerns with clients. Also, further research on the impact of age on therapeutic alliance and the impact of gender on attrition across different settings is also warranted.

A potential future study that can expand on this research might implement the intervention in real-time cross-cultural therapy. Similar to this study, the future research can focus on the first session of treatment and can involve the therapist broaching the cultural difference while providing the opportunity for the patient to discuss his or her concerns at the present or a future session. A researcher may want to apply the measures that were utilized in this study in order to evaluate therapeutic alliance, cross-cultural competency, and attrition. A researcher might also follow up with these measures in a longitudinal study design. A study such as this might be a valuable opportunity to evaluate whether acknowledging visible cultural differences in a true therapeutic session would impact therapeutic alliance, cross-cultural competency, and attrition. These findings may provide further evidence for the value of discussing cultural difference in

the early sessions of treatment and how such discussions may benefit the client.

## References

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*(5), 377-402.

Antoniou, P., & Cooper, M. (2013). Psychological treatments for eating disorders: What is the importance of the quality of the therapeutic alliance for outcomes? *Counselling Psychology Review*, *28*(4), 34-46.

Arnow, B. A., Blasey, C., Manber, R., Constantino, M. J., Markowitz, J. C., Klein, D. N., . . . Rush, A. J. (2007). Dropouts versus completers among chronically depressed outpatients. *Journal of Affective Disorders, 97*(1-3), 197-202.

Asnaani, A. A., & Hofmann, S. G. (2012). Collaboration in multicultural therapy: Establishing a strong therapeutic alliance across cultural lines. *Journal of Clinical Psychology*, *68*(2), 187-197.

Aubuchon-Endsley, N. L., & Callahan, J. L. (2009). The hour of departure: Predicting attrition in the training clinic from role expectancies. *Training and Education in Professional Psychology, 3*(2), 120-126.

Austin, A., & Wagner, E. (2010). Treatment attrition among racial and ethnic minority youth. *Journal of Social Work Practice in the Addictions*, 10(1), 63-80.

Barrett, M. S., Chua, W., Crits-Christoph, P., Gibbons, M., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training, 45*, 247-267.

Barter, C., & Renold, E. (2000). 'I wanna tell you a story': Exploring the application of vignettes in qualitative research with children and young people. *International Journal of Social Research Methodology, 3*(4), 307-323.

Beckham, E. (1992). Predicting client dropout in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 29*(2), 177-182.

Bedi, R. P., & Richards, M. (2011). What a man wants: The male perspective on therapeutic alliance formation. *Psychotherapy, 48*, 381-390.

Benet-Martınez, V., & Haritatos, J. (2005). Bicultural identity integration (BII): Components and psychosocial antecedents. *Journal of Personality, 73,* 1015–1050.

Biever, J. L., Castaño, M., de las Fuentes, C., González, C., Servín-López, S., Sprowls, C., & Tripp, C. G. (2002). The role of language in training psychologists to work with Hispanic clients. *Professional Psychology: Research and Practice, 33*, 330-336.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16*(3), 252−260.

Brown, D. L., & Pomerantz, A. M. (2011). Multicultural incompetence and other unethical behaviors: Perceptions of therapist practices. *Ethics and Behavior, 21*, 498-508.

Burns, D. (1989). *The feeling good handbook*. New York, NY: Morrow.

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and clinicians in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, *58*, 537-554.

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*, *56*, 521-536.

Cohen, A. B. (2009). Many forms of culture. *American Psychologist*, *64*(3), 194-204.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (Rev. ed.). Hillsdale, NJ: Erlbaum.

Collett, J. L., & Childs, E. (2011). Minding the gap: Meaning, affect, and the potential shortcomings of vignettes. *Social Science Research*, *40*, 513-522.

Cournoyer, L., Brochu, S., Landry, M., & Bergeron, J. (2007). Therapeutic alliance, client behaviour and dropout in a drug rehabilitation programme: The moderating effect of clinical subpopulations. *Addiction*, *102*,1960-1970.

Day-Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, M. J. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development*, *85*(4), 401-409. Retrieved from http://www.counseling.org/publications/counseling-journals.

Duff, C. T., & Bedi, R. P. (2010). Counsellor behaviours that predict therapeutic alliance: From the client's perspective. *Counselling Psychology Quarterly*, *23*(1), 91-110.

Elvins, R., & Green, J. (2008). The conceptualization and measurement of therapeutic alliance: An empirical review. *Clinical Psychology Review, 28* 1167-1187.

Gehart, D. R., & Lyle, R. R. (2001). Client experience of gender in therapeutic relationships: An interpretive ethnography. *Family Process*, *40*, 443-458.

Hayes, S. A., Hope, D. A., VanDyke, M. M., & Heimberg, R. G. (2007). Working alliance for clients with social anxiety disorder: Relationship with session helpfulness and within-session habituation. *Cognitive Behaviour Therapy*, *36*(1), 34-42.

Hays, P. A. (1996). Addressing the Complexities of Culture and Gender in Counseling. *Journal Of Counseling & Development, 74*(4), 332-338.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*(2), 223-233.

Hughes, R., & Huby, M. (2002). The application of vignettes in social and nursing research. *Journal of Advanced Nursing*, *37*(4), 382-386.

Hyer, L., Kramer, D., & Sohnle, S. (2004). CBT with older people: Alterations and the value of the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training*, *41*(3), 276-291.

Ivey, D. C., Wieling, E., & Harris, S. M. (2000). Save the young—the elderly have lived their lives: Ageism in marriage and family therapy. *Family Process*, *39*(2), 163-175.

Johnson, L. A., & Caldwell, B. E. (2011). Race, gender, and therapist confidence: Effects on satisfaction with the therapeutic relationship in MFT. *American Journal of Family Therapy*, *39*(4), 307-324.

King, A., & Canada, S. (2004). Client-related predictors of early treatment drop-out in a substance abuse clinic exclusively employing individual therapy. *Journal of Substance Abuse Treatment*, *26*(3), 189-195.

Knight, B. G., & Satre, D. D. (1999). Cognitive behavioral psychotherapy with older adults. *Clinical Psychology: Science and Practice, 6*(2), 188-203.

Knox, S., Burkard, A. W., Suzuki, L. A., & Ponterotto, J. G. (2003). African American and European American clinicians' experiences of addressing race and cross-racial psychotherapy dyads. *Journal of Counseling Psychology, 50,* 466–481.

LaFromboise, T. D., Coleman, H. L., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory—Revised. *Professional Psychology: Research and Practice*, *22*(5), 380-388.

La Roche, M. J., & Maxie, A. (2003). Ten considerations in addressing cultural differences in psychotherapy. *Professional Psychology: Research and Practice*, *34*(2), 180-186.

Leong, F. T. (1986). Counseling and psychotherapy with Asian-Americans: Review of the literature. *Journal of Counseling Psychology, 33*(2), 196-206.

Levy, J. J., Thompson-Leonardelli, K., Smith, N., & Coleman, M. (2005). Attrition after intake at a university counseling center: Relationship among client race, problem type, and time on a waiting list. *Journal of College Counseling*, *8*(2), 107-117.

Luborsky, L. (1984). *Principles of psychodynamic psychotherapy*. New York, NY: Basic Books.

Mancino, M., Curran, G., Han, X., Allee, E., Humphreys, K., & Booth, B. M. (2010). Predictors of attrition from a national sample of methadone maintenance clients. *The American Journal of Drug and Alcohol Abuse, 36*(3), 155-160.

Martin, D. J., Garske, J. P., & Davis, K. M., (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting & Clinical Psychology, 68,* 438. Retrieved from http://www.apa.org/pubs/journals/ccp/index.aspx.

Maxie, A. C., Arnold, D. H., & Stephenson, M. (2006). Do clinicians address ethnic and racial differences in cross-cultural psychotherapy?. *Psychotherapy: Theory, Research, Practice, Training, 43*(1), 85-98.

Miller, L. M., Southam-Gerow, M. A., & Allin, R. R. (2008). Who stays in treatment? Child and family predictors of youth client retention in a public mental health agency. *Child & Youth Care Forum, 37*(4), 153-170.

Mio, J. S., Barker-Hackett, L., & Tumambing, J. (2006). *Multicultural psychology: Understanding our diverse communities*. New York, NY: McGraw-Hill.

Moleiro, C. C., Freire, J. J., & Tomsic, M. M. (2013). Immigrant perspectives on multicultural competencies of clinicians: A qualitative study with immigrants in Portugal. *International Journal of Migration, Health and Social Care*, *9*(2), 84-95.

Moore, A., & Barker, G. (2012). Confused or multicultural: Third culture individuals' cultural identity. *International Journal of Intercultural Relations, 36*(4), 553-562.

Nezu, A. M. (2010). Cultural influences on the process of conducting psychotherapy: Personal reflections of an ethnic minority psychologist. *Psychotherapy: Theory, Research, Practice, Training*, *47*(2), 169-176.

Olfson, M., & Marcus, S. C. (2010). National trends in outpatient psychotherapy. *The American Journal of Psychiatry*, *167*, 1456-1463.

Orlinsky, D. E., & Howard, K. I. (1975). *Varieties of psychotherapeutic experience: Multivariate analysis of clients' and clinicians' reports*. New York, NY: Teachers College Press.

Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy*, *48*(3), 274-282.

Pakes, K., & Roy-Chowdhury, S. (2007). Culturally sensitive therapy? Examining the practice of cross-cultural family therapy. *Journal of Family Therapy*, *29*(3), 267-283.

Reis, B., & Brown, L. (2006). Preventing therapy dropout in the real world: The clinical utility of videotape preparation and client estimate of treatment duration. *Professional Psychology: Research and Practice*, *37*(3), 311-316.

Ridley, C. R., & Shaw-Ridley, M. (2011). Multicultural counseling competencies: An analysis of research on clients' perceptions: Comment on Owen, Leach, Wampold, and Rodolfa (2011). *Journal of Counseling Psychology*, *58*(1), 16-21.

Saltzman, C., Leutgert, M. J., Roth, C. H., Creaser, J., & Howard, L. (1976). Formation of a therapeutic relationship: Experiences during the initial phase of psychotherapy as predictors of treatment duration and outcome. *Journal of Consulting and Clinical Psychology*, *44*, 546-555.

Sánchez, M., Cardemil, E., Adams, S., Calista, J. L., Connell, J., DePalo, A., . . . Rivera, I. (2014). Brave new world: Mental health experiences of Puerto Ricans, immigrant Latinos, and Brazilians in Massachusetts. *Cultural Diversity and Ethnic Minority Psychology*, *20*(1), 16-26.

Schwartz, S. J., Montgomery, M. J., & Briones, E. (2006). The role of identity in acculturation among immigrant people: Theoretical propositions, empirical questions, and applied recommendations. *Human Development, 49*(1), 1-30. Retrieved from http://www.karger.com/Journal/Home/224249.

Schwartz, S., Zamboanga, B., Rodriguez, L., & Wang, S. (2007). The structure of cultural identity in an ethnically diverse sample of emerging adults. *Basic and Applied Social Psychology*, *29*(2), 159-173.

Sharf, J., Primavera, L. H., & Diener, M. J. (2010). Dropout and therapeutic alliance: A meta-analysis of adult individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 47*, 637-645.

Singer, R. R., & Tummala-Narra, P. (2013). White clinicians' perspectives on working with racial minority immigrant clients. *Professional Psychology: Research and Practice*, *44*(5), 290-298.

Stamler, V., Christiansen, M. D., Staley, K. H., & Macagno-Shang, L. (1991). Client preference for counselor gender. *Psychology of Women Quarterly*, *15*, 317-321.

Startup, M., Wilding, N., & Startup, S. (2006). Patient treatment adherence in cognitive behaviour therapy for acute psychosis: The role of recovery style and working alliance. *Behavioural and Cognitive Psychotherapy, 34*(2), 191-199.

Sterling, R., Gottheil, E., Weinstein, S., & Serota, R. (1998). Therapist/patient race and sex matching: treatment retention and 9-month follow-up outcome. *Addiction, 93*(7), 1043-1050.

Sue, S., & McKinney, H. (1975). Life strengths and life stresses: Explorations in the measurement of the mental health of the Black aged. *The American Journal of Orthopsychiatry, 45*(1), 111-118.

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 80*, 547-559.

Tartakovsky, E. (2009). Cultural identities of adolescent immigrants: A three-year longitudinal study including the pre-migration period. *Journal of Youth and Adolescence, 38*, 654-671.

Thompson, V. L. S., Bazile, A., & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice, 35*(1), 19-26.

Tryon, G. S., & Kane, A. S. (1993). Relationship of working alliance to mutual and unilateral termination. *Journal of Counseling Psychology, 40,* 33–36.

Tsang, A. A., Bogo, M., & Lee, E. (2011). Engagement in cross-cultural clinical practice: Narrative analysis of first sessions. *Clinical Social Work Journal*, *39*(1), 79-90.

Vasquez, M. (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist, 62*, 878-885.

Wade, P., & Bernstein, B. L. (1991). Culture sensitivity training and counselor's race: Effects on Black female clients' perceptions and attrition. *Journal of Counseling Psychology, 38,* 9–15.

Warden, D., Rush, A., Wisniewski, S., Lesser, I., Thase, M., Balasubramani, G., . . . Trivedi, M. (2009). Income and attrition in the treatment of depression: A STAR*D report. *Depression & Anxiety (1091-4269), 26*, 622-633.

Werner-Wilson, R., & Winter, A. (2010). What factors influence therapy drop out? *Contemporary Family Therapy: An International Journal*, *32*(4), 375-382.

Wilensky, H., & Weiner, M. (1977). Facing reality in psychotherapy with the aging. *Psychotherapy: Theory, Research & Practice*, *14*(4), 373-378.

Wintersteen, M. B., Mensinger, J. L., & Diamond, G. S. (2005). Do gender and racial differences between client and clinician affect therapeutic alliance and treatment retention in adolescents? *Professional Psychology: Research and Practice, 36,* 400-408.

Yoon, E., Chang, C., Kim, S., Clawson, A., Cleary, S., Hansen, M., . . . Gomes, A. M. (2013). A meta-analysis of acculturation/enculturation and mental health. *Journal of Counseling Psychology*, *60*(1), 15-30.

## Appendix A

## Client Attrition Questionnaire

**Based on the vignette that you have just read, and your limited experience with this hypothetical therapist, how likely would you be to do each of the following:**

**1. Not return after the first session? (Please circle the rating below)**

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
|---|---|---|---|---|---|---|---|---|
| **Not likely** | | | | **Probably** | | | | **Extremely likely** |

**2. Not return after the 3rd session?**

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
|---|---|---|---|---|---|---|---|---|
| **Not likely** | | | | **Probably** | | | | **Extremely likely** |

**3. Complete the course of therapy?**

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
|---|---|---|---|---|---|---|---|---|
| **Not likely** | | | | **Probably** | | | | **Extremely likely** |

## Appendix B

Instructions for Graduate Student

1. The Graduate Assistant (GA) will provide adult subjects at the Center for Brief Therapy a flyer that contains information about the study. Each subject would only receive the flyer once, and the flyer can be given to both new and current subjects. *There will be a total of 36 subjects, with 9 subjects in each of 4 groups.*

2. When a subject expresses a desire to take part in the study, the GA will inform the student investigator of the subjects desire to participate, in which the student investigator will introduce the study to the subject. In the event that the student investigator is not present, the GA will invite the subject into the front office to review the informed consent form. The GA will read the informed consent form to the subject.

3. Following the signing of the informed consent form, the GA will provide the subject a packet based on the random distribution pattern that will be posted at the front desk. The packets will be kept in a basket in the main office, and will be separated into 4 baskets that contain 4 different vignettes labeled “A”, “B”, “C” and “D”. The vignette distribution form is a random distribution of each packet to a subject. The GA will cross off the subject from the vignette distribution form once the packet is distributed, and proceed to the next subject on the form.

4. Once the subject completes the packet, he or she will return it back to the GA, who will then provide the subject the $5 Visa gift card from an envelope containing the cards.

5. The GA will then seal and place the completed packet in the student investigators mailbox at the CBT.

## Appendix C

## Vignette Distribution Form

Instructions: Distribute the appropriate vignette (labeled A, B, C, or D) to the next subject on the list who has not yet received a vignette. Please cross out a subject once a vignette has been distributed.

Randomly Distributed Vignette List:

| | | | |
|---|---|---|---|
| 1. B | 10. C | 19. D | 28. C |
| 2. D | 11. D | 20. C | 29. C |
| 3. B | 12. D | 21. C | 30. A |
| 4. A | 13. B | 22. A | 31. B |
| 5. A | 14. D | 23. B | 32. C |
| 6. A | 15. B | 24. D | 33. D |
| 7. B | 16. A | 25. B | 34. A |
| 8. D | 17. A | 26. C | 35. A |
| 9. B | 18. C | 27. C | 36. D |

## Appendix D

## PCOM Study Description

At PCOM, we are conducting a study to assess ways in which we can improve the therapeutic relationship, while taking cultural differences into account. I will ask that you read a vignette and complete 3 forms that ask your opinion about the therapist in the vignette and of future decisions that you may make based on your impressions. We would also ask that you please complete these forms in the waiting room and return them to the graduate assistant or student investigator in the front office when you are finished. Participation in this study will qualify you to receive a $5 Visa gift card.

Please note that participation in this study is optional, and will not impact your treatment. Also, you may elect to drop out of the study at any time.

Thank you for your time and participation.

Sincerely,

Dr. Bruce Zahn, Ed. D., ABPP
Professor
Department of Psychology
Philadelphia College of Osteopathic Medicine

Jean-Pierre Assouad, M.S.
Study Investigator
Philadelphia College of Osteopathic Medicine

## Appendix E

## Vignettes

Vignette A:

Broaching Race

You are meeting your therapist for your first session. You have spoken over the phone about a week ago to set up an appointment and briefly discuss why you are coming to treatment. You have no idea what your therapist looks like.

After sitting in the waiting room for a few minutes, your therapist comes out to bring you back into the office. Physically, you take notice that your therapist is around the same age as yourself and that he is of a different race. The therapist introduces him or herself and works with you to discuss what will take place in today's session. During the session, you and your therapist discuss your reasons for coming into treatment. You provide your therapist with some medical and family history. The therapist listens to your concerns, and takes down some notes throughout the session. Your therapist discusses the type of therapy that he practices and expresses that he would be able to treat your condition. He or she also provides you with an idea of what treatment would look like and asks you throughout the session whether you have any questions.

Towards the end of the session, the therapist puts away the intake paperwork and expresses that he would like to hear your feedback about something. The therapist makes the statement, "I noticed that we are both from different races. I was just wondering if you have any concerns about that?" You express to your therapist how you feel, and the session ends shortly after.

Vignette B:

Broaching Age

You are meeting your therapist for your first session. You have spoken over the phone about a week ago to set up an appointment and briefly discuss why you are coming to treatment. You have no idea what your therapist looks like.

After sitting in the waiting room for a few minutes, your therapist comes out to bring you back into the office. Physically, you take notice that your therapist is likely the same race as yourself, however you notice that your therapist is significantly different age than yourself. The therapist introduces him or herself and works with you to discuss what will take place in today's session. During the session, you and your therapist discuss your reasons for coming into treatment. You provide your therapist with some medical and family history. The therapist listens

to your concerns, and takes down some notes throughout the session. Your therapist discusses the type of therapy that he practices and expresses that he would be able to treat your condition. He or she also provides you with an idea of what treatment would look like and asks you throughout the session whether you have any questions.

Towards the end of the session, the therapist puts away the intake paperwork and expresses that he or she would like to hear your feedback about something. The therapist makes the statement, "I noticed that we are both very different in age. I was just wondering if you have any concerns about that?" You express to your therapist how you feel, and the session is concluded shortly after.

Vignette C:

Broaching Race and Age

You are meeting your therapist for your first session. You have spoken over the phone about a week ago to set up an appointment and briefly discuss why you are coming to treatment. You have no idea what your therapist looks like.

After sitting in the waiting room for a few minutes, your therapist comes out to bring you back into the office. Physically, you take notice that your therapist is around the significantly different age than yourself and is of a different race. The therapist introduces him or herself and works with you to discuss what will take place in today's session. During the session, you and your therapist discuss your reasons for coming into treatment. You provide the therapist with some medical and family history. The therapist listens to your concerns, and takes down some notes throughout the session. Your therapist discusses the type of therapy that he practices and expresses that he would be able to treat your condition. He or she also provides you with an idea of what treatment would look like and asks you throughout the session whether you have any questions.

Towards the end of the session, the therapist puts away the intake paperwork and expresses that he would like to hear your feedback about something. The therapist makes the statement, "I noticed that we are both very different in age, and also of different races. I was just wondering if you have any concerns about that?" You express to your therapist how you feel, and the session is concluded shortly after.

Vignette D:

Not Broaching Race and Age

You are meeting your therapist for your first session. You have spoken over the phone about a week ago to set up an appointment and briefly discuss why you are coming to treatment. You have no idea what your therapist looks like.

After sitting in the waiting room for a few minutes, your therapist comes out to bring you back into the office. Physically, you take notice that your therapist is around the significantly different age than yourself and is of a different race. The therapist introduces him or herself and works with you to discuss what will take place in today's session. During the session, you and your therapist discuss your reasons for coming into treatment. You provide the therapist with some medical and family history. The therapist listens to your concerns, and takes down some notes throughout the session. The therapist discusses the type of therapy that he practices and expresses that he would be able to treat your condition. He or she also provides you with an idea of what treatment would look like and asks you throughout the session whether you have any questions.

Towards the end of the session, the therapist puts away the intake paperwork and asks whether you have any questions or concerns. You decide whether or not to bring up the racial or age differences. Following any questions that you may have asked, the therapist concludes the session.